Tuneral Director Social Social Name (if not institution give street and number) 4b. City, Town, or Location of Death 4b. City, Town, or Location of Death 4b. City, Town or Location 5b. Social Social Social Number 5b. Social S	9. Fime-of Death N/A 9. Birthplace (State or Foreign NY) 10d. Inside City Limits 1 Yes 2 No of What Country? U.S.A. Race - American Indian, Black, White, etc. icify: WHITE if Business/Industry GOVERNMENT name)
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MILTON GOLDBERG PEARL 19b. Mailing Address (Street and Number or Rural Route Number, City or To 20 per	name)
20a. Method of Disposition September S	BERNSTEIN
20a. Method of Disposition September S	
20a. Method of Disposition September S	
1 Burial 2 Cremation 3 Removal from State B NAI ISRAEL CEM. 7/11/2004 PENSAI 1 PENSAI 1 PENSAI 22. Name and Address of Facility SOL LEVINSON & 8900 REISTERSTOWN ROAD - PIKESV 23a. Part Entre the pissase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or figar failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulped Pensai Pensa	on - City or Town, State
23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	OLA FL
23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between
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Sequentially list conditions, fa any, leading to immediate cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown	
C. Due to (or as a consequence of): Open continuous of the part	8 Months
C. Due to (or as a consequence of): Open continuous of the part	
O the part of the	3
The state of the s	
23d. If FEMALE: 23d. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. 23d.	
Sport of the past 12 months? 1 Yes 2 No 9 Unknown 2 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 2 Yes 2 Yes 2 No Yes 2 Yes	Date of delivery
Span of the first of the following of the first of the following of the first of the following of the follow	Month Day Year
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Type 2 diabets 24a. Was an autopsy	3 Probably 4 Unknown
	b. Were autopsy findings available prior to completion of cause of
e e e e e e e e e e e e e e e e e e e	death? 1 ☐ Yes 2 🕱 No
Performed? 1	R. 2000 - 2000
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at 28c. Injury at 28d. Describe how injury oc Injury 28c. Injury at 28c. Injury at 28d. Describe how injury oc Injury 3 Accident investigation M 1 Yes 2 No	ourred
O D S S Suicide 1 S Suicide 2 Accident investigation M 1 Yes 2 No 2 S Suicide 3 Suicide 6 Could not be determined 286. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and No.	
27. Manner of Death Salation	mber or Rural Route Number.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and	imber or Rural Route Number,
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 4 Homicide 2 Accident 5 Pending investigation 6 Could not be determined 6 Could not be determined 6 Could not be determined 7 Pending investigation 6 Could not be determined 7 Pending investigation 8 Place of Injury At home, farm, street, factory, office 9 Place of Injury At home, farm, street, factory, office 9 Place of Injury At home, farm, street, factory, office 9 Place of Injury At home, farm, street, factory, office 9 Place of Injury At home, farm, street, factory, office 9 Place of Injury At home, farm, street, factory, office 9 Place of Injury At home, farm, st	manner as stated.
	manner as stated.
TO TO RES-000 7/10	manner as stated. ce, and due to the cause(s) gned (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	manner as stated. ce, and due to the cause(s) gned (Month, Day, Year)
	manner as stated. ce, and due to the cause(s) gned (Month, Day, Year)
State 31. Date filed (Month, Day, Year) 32. hegistrar's Signature 33. Registrar's Signature	manner as stated. ce, and due to the cause(s) gned (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) , Day 2004 Year July Physician 9, 4:44p M John H. Green, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Towson Baltimore Co. Gilchrist Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 37 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1**№** M 2□ F 222-22-3697 67 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Harford Co. Street, MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 1413 Whiteford Road 21154 USA or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 阿No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. should be filed within 72 hours after ond Mental Hygiene. markad other than "naturel", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farrier Horse Racing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill h and Mental H r is markad oth John C. Green. Ruth Isaacs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Sackett St. Brooklyn, NY 11231 9a. Informant's Name/Relationship (Type, Print) Elizabeth Green-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or conce. 1 ■ Burial 2 Cremation 3 Removal from State St. Annes Cemetery 7-15-04 Middletown, DE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses MO1259 Danarel dad & Hutchison Funeral Home Broad St Middletown, DE 19709 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ears disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2/2/No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Peath 28d. Describe how injury occurred Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician

July 9, 2004

10

Registrar

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

JUL 1 3 2004

(HAZUE) MO (ear) 32, Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

long

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

83

29d. Date signed (Month, Day, Year)

horles St Baltmore MB

DHMH 17 Rev 1/2001

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		-	For State of M		artment of Healtl rtificate of Dea	h and Mental Hyg th	giene Reg. Ng2 0 0 4 2 2 0 0 3
	Physici	an	1. Decedent's Name (First, Middle, Last) Lucia Sheila Hawthorne			2. Date of Dea	Day_ Yeer 20 200
	/Medic Examin	al .	4a. Fecility Name (If not institution, give street and number) Good Saman tan Ko	spital	4b. City, Town, or Location	ion of Death 7 moke	4c. County of Death
	Funeral Director			(In yrs. last birthday) 68 Yrs.	If Under 1 Year If Under 1 Year Hour	order 24 Hrs. 8. Date of Birt (Month, Da May 6,	th y, Year) 9. Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	ctor	MD	В	altimore		t¶ Yes 2 □ No
	with th	Director	10e. Street and Number 115 E. Melrose Avenue		10f. Zip Code 21212		10g. Citizen of What Country?
	ter death w Itams 23a	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic	Origin? (Specify Yes or No	USA 14. Race - American Indian,
920	or Ita	by	Armed Forces' 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☑ No Spec		Black, White, etc. Specify: black
21215-0036	C * 10	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life.	odent's Usual Occupation o kind of work done during r DO NOT use retired)	most of working	16b. Kind of Business/Industry
	Hygi Hygi Sther	0	17. Father's Name (First, Middle, Last)	Į pi		lother's Name (First, Middle,	university Maiden Sumame)
ylan	Q & D &	To B	Edward W. Hawthorne			Daisy Goins	
Maryland	12 sho h and ris ma		19a. Informant's Name/Relationship (Type, Print) Jean Hawthorne/sister			umber or Rural Route Number Way Halethor	er, City or Town, State, Zip Code)
Baltimore, I	leges 1 and 2 should set of Health and Merit! If item 27 is marke y or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disp	The second secon	Date	20c. Location - City or Town, State
Baltin	permit. Pege Depertment of Importent: If any injury or once.		2 Signature of Funeral Service Licensee	ector S	2. Name and Address of Fa tate Anatomy altimore, MD	Board 655 W.	Baltimore Street
8760,	Physician / Medical Examiner and physician and physician and the private and t	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ine. Lef ves a consequence of): Author a consequence of): a consequence of):	occal	distress s Preum	Interval Between Onset and Death Yndroine Loufa
Box 6		by Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Vital Records, P.O	aw requires tha is been signed 2 should be de	Completed by Ph	Part II. Other significant conditions contributing to death Drabetes me Advanced peri	but not resulting in the	underlying cause given in P type 2 proceedor	dislane 24a. Was	an 24b. Were autopsy findings available prior to completion of cause of
a B	ician: The l certificate ha rector, page	Con	,	7		1 ☐ Yes	ormed? death? 207No 1 ☐ Yes 207No
. Vit	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Yinpat	ient 2 ER/Outpatie	Other	Place of Death <i>(Check only o</i> ☐ Nursing Home 5 ☐ Resi	one) dence 6 □Other (Specify)
n of	ding Phy h. After thi funeral	on: 1	27. Manner of Death t Natural 5 Pending (Month, D	ury 28b. Time ay Year) Injury	Work?		how injury occurred
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Ir	njury - At home, farm, s tc. <i>(Specify)</i>	M 1 ☐ Yes 2		Street and Number or Rural Route Number, wn, State)
J	To the Hospitel or Attentwith 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the bess 2 Medical Exeminer: On the basis and manner and manner services.	of examination and/or i			cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	MD	29c. License numb	Der 000	29d. Date signed (Month, Day, Year) June 05, 2004
			30. Name and address of person who completed cause of SOR AS CICATUROV. 31. Date filed (Month, Day, Year) 32. Regis	death (Item 23a) (Type 5601 Loc	H Raven K	BoulevarD,	Baltmore, MD 21239
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regis JUL 13 200	trar's Signature	J. Gosethe	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 30, 2004 Ronan Richard Hoffman 9:00 A June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
April 12,1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**⊠**M 2□F 83 Director 122-03-5078 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Maxilcal Examiner must be notified at 1 Yes X No Howard Columbia Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10539 Tolling Clock Way 21044 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Deputy Department Director 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be f nd Mental I Lawrence Raymond Hoffman Sarah Nancy Largett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i Mary Z. Hoffman / Wife 10539 Tolling Clock Way Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 07/01/04 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Euneral Service Licensee ^{22, Name and Address of Facility} Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, MD 212<u>28</u> Thomas Gregor O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Achexia ear Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transi Due to (or as a consequence of): 68760, ed by the attending physicien detached for use as the buria Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ate has been signed by a page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No his funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto and 21204 GBMC 6701 KI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

2004

			Please Type or Print in Black I		
			1 - State Registrar Co	partment of Health and Mer pertificate of Death	Reg. No. 2004 22005
н	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 11V 8 2004 8:06 P M
	/Media	cal	Doris Augusta Hellstern 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11y 8 2004 8:06 P M 4c. County of Death
1	Examir	ner	Genesis Eldercare - Randallstown	Randallstown	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8	Date of Birth 9. Birthplace (State or Foreign
	Director		$212-05-1781$ $^{1\squareM}$ 2	Morius Days Hours Min. Ap	ril 12, 1914 New Jersey
	aryian show	_	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
	Ba-f s	ecto		11stown	1 ☐ Yes 2 XNo
	with ti	Dir.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	leath	erai	9109 Liberty Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21133	Ves or No- 14. Race - American Indian,
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	I. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	nn, etc.) Black, White, etc.
8	ours a	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 XX No Specify:	Specify: white
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12	withir ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+)	clerical	unknown
9	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Sumame)
ılan	Jenta Jenta rked tic ev	To B	unknown	Florence	(unknown)
Maryland	2 should be filed within n and Mental Hygiene. Is marked other than "reumatic evant, the Mee			iling Address (Street and Number or Rural Ro	oute Number, City or Town, State, Zip Code)
	1 and 2 Health am 27 I			. Calvert St., Suite	
Jore	iges 1 nt of Ho If Itan or oth		T Durial E Moraliation o Directionation of the	position (Name of Date ematory or other place)	20c. Location - City or Town, State
altimore,	permit. Pages 1 a Department of Hes Important: If Itam any injury or othe once.	119			,2004 Baltimore, Maryland
Ba	permit. Pages 'Department of H Important: If Its any injury or ot once.		John O. Mitchell	Mitchell-Wiedefe 6500 York Rd.	ld Funeral Home, Inc. Baltimore, MD 21212
			23a. 9411. Enter the disease, or complications that caused the death. Do not a mock, or heart failure. List only one cause on each line.	y ·	spiratory arrest, Approximate Interval Between Onset and Death
	Priysician /Medical	r i	resulting in death)	-daosis	20 years
	Examiner		Due to (or as a consequence of):		
	a	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury)		
	cuted nd iransit	Examine	triat initiated events C.		
,09/	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
6876	eath certificate b attending physic for use as the b	dicai	d		
9 X	certifi Iding I	/We	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Pate of delicery
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medic	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
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of Vital Records,	law r	Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
<u>=</u>		Sol			performed death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
VIE	Physiclan: this certificatal director, I	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Ch	
	<u>a</u> + <u>a</u>	: To	1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ Inpatient 2 ☐ ER/Outpati 27. Manne of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	ent 3 DUA Nursing Home	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
ion	E # F	atio	1 ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. I	Location (Street and Number or Rural Route Number, City or Town, State)
	ital or irs afte ral Diri		Sulfaring, stat. (Spootily)	4	
	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, der 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and dinvestigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
	To the To the Comp	ğ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•			, the HUM	D0020964	7/12/04
	1		30. Name and address of person who completed cause of death (Item 23a) (Type		
	Sta	to.	Jerome H. Ginsberg, M.D. 8630 Liber 31. Date filed (Month, Day, Year) 32. Registrar's Signature	cty Plaza Mall Randal	1stown, MD 21133
	Registr	. •	JUL 1 3 2004		
			June 1	Pade 1	

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#	Bal
	P.O. Box 68760,
	tal Records, P.O.
	To to

	Please Type or Print in Black Indelible Ink. Ensure All State of Maryland / Department of Health and Me 1- For Registrar Certificate of Death	-	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Marie Theresa Hammond	2. Date of Death Month Day July 9, 2	3. Time of Death Year 9:30 P ^M
Examiner Funeral Director	Months Days Hours Min.		
death with the Maryland ms 23a or 28a-f show rount be notified at	10a. State 10b. County 10c. City, Town or Location Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code	10g. Citize	10d. Inside City Limits 1 ☐ Yes 2 💢 No en of What Country?
21215-0036 ed within 72 hours after death with the Marygiene. In the Medical Exaction must be notified. Completed by Funeral Director	3570 Court House Drive, Apt. 3+C 21043 11. Marital Status 1 Never Married 2 Married 3 Warried 3 Widowed 4 X Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1970-73	US ify Yes or No- ican, etc.)	·
21215-0036 di within 72 hours afigiene. or than "natural", or than "natural", or the Medical Exercition of the Medical Exe	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17 College (1-4or 5+) 18 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager	7	of Business/Industry
Maryland 2 Id 2 should be filed at 2 should be filed 77 is marked other 1 traumetic event, I	17. Father's Name (First, Middle, Last) Carmine Jerry Gallo 18. Mother's Name (Helen	First, Middle, Maiden S Rose Torr	umame) :usio
Baltimore, Maryland 21215-0036 Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumetic event, the Medical Exaction must be notified at once. To Be Completed by Funeral Director	Anne Marie Hammond/Daughter 3570 Court House Irive. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signation of Euneral Service Licensee 1 Cremation 2 Cremation 2 Cremation 3 Cresorchik 22. Name and Address of Facility Cremation Society Crematical Crematic	Apt. 3-C, 20c. Loca 04 Bal	Ellicott City, Mu ation City or Town, State
760, te be executed Tysician and the burial-transit the beautiful to be a secure of the beautiful to be a secure of the burial-transit the beautiful to be a secure of	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	rescirating arrest,	Approximate Interval Between Onset and Death
If Records, P.O. Box 6876: The law requires that the death certificate beate has been signed by the attending physic page 2 should be detached for use as the becompleted by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)	23	id. Date of delivery Month Day Year
cords, P.O. w requires that the de been signed by the should be detached leted by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death? No 3 Probably 4 Unknown
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Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification; To Be (examiner? 1	e 5 Residence 6	ther (Specify) HOSP Coocurred Number or Rural Route Number,
Lithe Hospital thin 24 hours is the Funeral I mpletely filled Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	nd due to the cause(s) a d at the time, date and p	nd manner as stated. clace, and due to the cause(s)
with Tot Comm	29b. Signature and title of certifier **Manual Balance** **Dood 57 45** 29 C. License number **Dood 57 45** 29 Dood 57 45** **True Print**	29d. Date	signed (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVID DEKE MAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature	harles St	Bat. MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (Fjrst, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mon wand 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Examiner Buttimoré Rehab NA Estanded CATE ar If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month Day Year) 9. Birthplace (State or Foreign Country) Mス **Funeral** Days Hours 1**∑** M 2□ F 217-07-5575 82 Yrs. Md. Director Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City, Town or Location framerical programments of the state of the 10d. Inside City Limits Md. NA Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 2201 Walbrook Ave. 12. Was Decedent Ever in U.S. Agned Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after effects of Health and Mental tygiene. ortant: if item 27 is marked other than "natural; or iten miury or other traumatic event, the Medical Examina 1 Never Married 2 Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done d. life. DO NOT use retired) during most of working Dept. Elementary/Secondary (0-12) 12th grade 2 yrs College (1-4or 5+) Baltimore City Police Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnson Blanche Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward S. Johnson, Jr. Son 206 Riverway Ct. Apt. 302, Owings Mills, Md. 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Druidridge Cem. 7-16-04 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 march F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. of enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician nEumoNIA De to (or as a consequence of): 0 disease or condition resulting in death) mont /Medical Examiner CANCER Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) detached Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Division of Vital 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After : Certification: 1 Natural 2 Accident 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide

To the Hospital

State Registrar

31. Date filed (Month, Day, Year) 3 2004

Quaren

29a, Certifier

(Check only one)

32. Registrar's Signature helin

m.D.

3900

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and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

100156

29d. Date signed (Month, Dav. Year)

			1- For State of Maryland / Dep. Registrar Ce	artment of Health and M	1ental Hygier	
	Dhoraiai		Decedent's Name (First, Middle, Last)		2. Date of Death	ay Year
	Physici /Medio		John Jordan Jr.		July 4	2004 5:00 A M
b	Examir	ner	4a. Facility Name (If not institution, give street and number) 314 Ryan Road	4b. City, Town, or Location of Death	4	Ac. County of Death
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Glen Burnie If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arundel 9. Birthplece (State or Foreign
	Director		219-03-0669 1½ M 2 F 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 6/23/1921	MARYLAND
	and *		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits
	Manyli i sho	ō	MD Anne Arundel Glen Bur			1 ☐ Yes XX No
	r 28a	Irec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	23a c	alD	314 Ryan Road	21061		USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or tema 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified a once.	by Funeral Director	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spet 1 Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
Ş	72 ho	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b.	Kind of Business/Industry
Maryland 21215-0036	within nne. then "	Completed	Elementary/Secondary (0-12) College (1-4015+)	kind of work done during most of worki DO NOT use retired)	-	efense
2	filed with Hygiene. other ther	ပိ	10 Sup 17. Father's Name (First, Middle, Last)	Dervisor 18. Mother's Name	(First, Middle, Maide	ontractor
<u>a</u>	Mental Mental rked c	To Be	Johann Jordan	Elizabet		
lary	2 should and Men is marke			ng Address (Street and Number or Rura		
	1 and 1 Health em 27			Ryan Rd., Glen Burn		
20	Pages nent of th int: if ite		20a. Method of Disposition 1 \(\overline{\text{District}} \) 2 \(\overline{\text{Cremation}} \) 3 \(\overline{\text{Removal from State}} \) 20b. Place of Disposition cemetary, credit to the property of	psition (Name of matory or other place) 1ge Memorial 7/9/2		Location - City or Town, State kridge, MD
Baltimore,	permit. Page Department Important: If any injury or once.		21. Sign fire it it meral Sovice Licensee 22	2. Name and Address of Facility Sir	ngleton Fu	neral Home P.A.
			234. Part1. Enter the disease, or complications that caused the death. Do not ent	Second Ave SW, G1e ter the mode of dying, such as cardiac of		Approximate
	Physician /Medical		Impediate Cause (Final disease or condition resulting in death)	- 1- AA	enay d	I Selve Interval Between Onset and Death
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	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
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Division of	tal or Attendestr's after death	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Centrier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invand manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the cause(s	s) and manner as stated. Id place, and due to the cause(s)
	To T	Σ	29b. Signature and title of settifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, ETEN MAMINEZM) TYS ONN W	Print) DON ND GENBUL	ME, MO,	21061
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Locals		
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		For S 1 - State Registrar	tate of Marylan		tment of F		-	giene Reg. No. 2	1 22000	
Physic /Medi	ical	1. Decedent's Name (First, Middle, Last) Mitchell Ralph K	osh		th City Town o	r Location of Dea	2. Date of De Month JULY	ath Day Yea	2:31 A M	
Funeral Director	ľ	4a. Facility Name (If not institution, give streets) St. Agnes Hospit 5. Social Security Number 6. Sex		last birthday)	Baltimo If Under 1 Year Wonths Days	ore	8. Date of Bir (Month, Da	th 9. I	Birthplace (State or Foreign Country)	
ס		21:7-84-7596 Usual Residence of Decedent 10a. State 10b. County		y, Town or Loca	tion		aprii	4, 1963	MD . 10d. Inside City Limits	
se Maryl 8e-f sho	Director	MD Baltimor	e Ba	altimo					1 ☐ Yes 2 No	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evard retrivative notified at once.	Completed by Funeral Dire	X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educati (Specify only highest grade co	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: on ompleted)	16a. Deceder	Yes 2 No	Specify: pation during most of wo	Specify Yes or Norto Rican, etc.)	Black, W Specify: A	umerican Indian, Ihite, etc. African	
ZIZ ZIGNE rgiene.	Comp	12	College (1-4or 5+)	Tru	ıck Dri	ver		Triple C	. Wholesale	
Maryland Z d 2 should be filed th and Mental Hygi ty is marked other treumatic event, it	To Be	17. Father's Name (First, Middle, Last) Richard Ralph Da	vis, Jr.			18. Mother's Na Hilda		, Maiden Sumame)		
farylan 2 should be and Mental Is marked eumatic ev	F	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	Address (Street	and Number or F	tural Route Numb	er, City or Town, State	e, Zip Code)	
IMOCE, M Pages 1 and 2 nent of Health sht: If item 27 l		Hilda Sollers 20a. Method of Disposition 1 XBurial 2 Cremation 3 Rem	oval from State	Place of Disposit cemetery, crema	ion (Name of tory or other plac	^{ce)} 7/0	Date	more, Md 20c. Location - City Elkridge	or Town, State	
Baltimore, permit. Pages 1 a Department of Her Importent: If item any injury or othe		' 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee	Mea Mo129	()	Name and Addre	ss of Facility W	itzke F	uneral H	iomes, Inc.	
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Attending Physical Colored Attending Physical Colored Phy			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	ry at		how injury occurred	poorly	
2 the c	Certification:	4 Homicide	28e. Place of Injury - At ho building, etc. <i>(Specif</i>	(y)			City or To			
To the Hospitel within 24 hours a To the Funerel Completely filled in	edical	29a. Certifier Check only one) Certifying Physici 2 Medical Examiner	an: To the best of my knoOn the basis of examina and manner stated.	owledge, death o ation and/or inve	stigation, in my c	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)	
To the within To the	Me	29b. Signature and title of certifier Rodorn Nicus	len, MD		29c. Licens			29d. Date signed (Mo	, , ,	
2		30. Name and address of person who comp	leted cause of death (Item, MD, ST AC	n 23a) (Type, Pr	int)					
Si Regis	tate trar	31. Date filed (Month, Day, Year) JUL 13 2004	32. Registrar's Signa	ature						

ORIGINAL

MITCHELL

KOSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1

Physician /Medical Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28e-f show any injury or other traumatic event, the Medical Evantinal roust ke routined at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State of Maryland / Department of Health and Mel	Reg. No. 0 0 1 2 2 0 1 0							
cian	1. Decedent's Name (First, Middle, Last) 2.	Date of Death Month Day Year Year 3. Time of Death							
dical iner	4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death	4c. County of Death							
al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. 8. Yrs. Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)							
r	212-10-0683 / 0 Ma	ay 9, 1918 Maryland							
or	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Owings Mills	10d. Inside City Limits 1 ☐ Yes 2 ☐ No							
Funeral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?							
nerai	11612 Garriosn Forest Road 21117 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Road of Hispanic Origin?)	y Yes or No- 14. Race - American Indian,							
d by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Black, White, etc. Specify: White							
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To Be Co	12 Telephone Operator 17. Father's Name (First, Middle, Last) Walter Taylor Telephone Operator 18. Mother's Name (First, Middle, Last) Ruth Mu	irst, Middle, Maiden Sumame) 11maW							
	19a. Informant's Name/Relationship (Type, Print) Verna L. Prichard Daughter 19b. Mailing Address (Street and Number or Rural R 11612 Garrison Forest R								
	20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Dongtion 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Druid Ridge Cemetery 7/13/2	200, 200, 200, 200, 200, 200, 200, 200,							
DIRE	21. Signal up of Funeral Service Licensee Agns: 22. Name and Address of Facility Burgee-Henss-Seitz I 3631 Falls Road, Bal	Funeral Home, Inc. 21211 Ltimore, Maryland							
	23a. Part1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resolved in the death of the death of the death of the mode of dying, such as cardiac or resolved in the death of the mode of dying, such as cardiac or resolved in the mode of dying in the mode o	Approximate Interval Between Onset and Death							
liner	Sequentially list conditions, if any, leading to immediate cause. Little thirderlying Cause (Disease or injury that initiated events c.								
edical Examiner	Due to (or as a consequence of):								
Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year							
ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 O 3 Probably 4 Unknown							
Complet		24a. Was an autopsy performed? 1 Yes 2 76 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
Be	25. Was case referred to medical examiner? Hospital: Other								
	12 Tipatient 2 Ervoupatient 3 DOA 4 Nutsing nome	5 Residence 6 Other (Specify) Describe how injury occurred							
- as	3 Coulette 6 Could not be	Location (Street and Number or Rural Route Number, City or Town, State)							
edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.								
N N	29b. Signature and title of certifier 29c. License number DY7206	29d. Date signed (Month, Day, Year)							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	SMI/5 MD211							
itate strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature & Sports	some full							
/2001	JUL 1 3 2004 A								

Registrar

		1 For State	State of Maryland / Dep		Mental Hygie	ne
Physic /Med Exami	cal	1. Decedent's Name (First, Middle, Last) DONALD E. 4a. Facility Name (If not institution, give s	LUDWIG	4b. City, Town, or Location of Dea	July 07	No. Vear 3. Time of Death Ac. County of Death
Funera Director		Northwest Hospita 5. Social Security Number 168-26-1998		Randallstown If Under 1 Year If Under 24 Hr Months Days Hours Mir		Baltimore 9. Birthplace (State or Foreign Country) PA. PA.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Thygiene "natural", or items 23e or 28e-1 show ont, the Medical Examiner must be notified at		Usual Residence of Decedent	10c. City, Town or L		04/21/17	10d. Inside City Limits 1 □ Yes 2 □ No
ath with the same at 200 or 2	rai Dire	3808 Offutt Road		10f. Zip Code 21133	U	Citizen of What Country? S.A.
0036 ours after de rral', or Item	d by Funeral Director	11. Marital Status 1 □ Never Married 2☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1- ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 sd within 72 hours aft giene. er then "natural", or the Medical Exem	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Give life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking	o. Kind of Business/Industry
INE, MARYIANG 21215-0036 I and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural, or Items 23e or 28e-1 show other traumatic event, the Medical Examiner must be notified at	To Be Co	17. Father's Name (First, Middle, Last) Wayne Ludwig		trical Engineer 18. Mother's Na Elva M	anufactoring den Sumame)	
re, Mar, 1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (Type Karen Ludwig		ing Address (Street and Number or Fi Offutt Road Ran	dural Route Number, Ci	
baltimore, IV permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce.		20a. Method of Disposition 1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Juneral Service License	Baltimore-	-Washington Cre 7	/10/2004 Laring Byers	Funeral Directors I
ate be executed Wedical Wiscian and Popularial-transit	icai Examiner	23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tary, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	ARTERIES D		Approximate Interval Between Onset and Death
The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of delivery Month Day Year		
wrequires that been signed be should be deta	by	Part II. Other significant conditions con-	tributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
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ding Phys	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of De th 1 Natural 5 Pending investigation	ospital: 1 Anpatient 2 ☐ EP/Outpatier 28a. D te of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	ath (Check only one) Home 5 Residence 28d. Describe how in	
Itel or Attending rs after death. ral Director: After	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, Sta	
To the Hospitel or Attention within 24 hours after deal To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical Examin 29b. Signature and title of certifier	cian: To the best of my knowledge, deatler: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	irred at the time, date a	and place, and due to the cause(s)
\$ 4 £ 4		> goginder 1 m	ehle m.o	D0041410) Jul	Oate signed (Month, Day, Year)
St. Regist	ite rar	30. Name and address of person who core address of p	32. Registrar's Signature	Print) JOHNEER P RANDAUSTUM SOOK		211 33.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 1435 M Ruth N. Luck エリム〉 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice-Mercy Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖾 F 215-12-1219 Yrs. Director 82 Aug 23,1921 Maryland (Maryland) Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or Items 23e or 28e-1 show other traumatic event, It e Medical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Ves 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 Wedgewood Road 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 전 No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2K No Specify: 3 Nidowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Garfield Newberry ဂ္ Nellie M. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Robert S. Luck, Jr. (Son) Silk Tree Court Catonsville, MD 21228 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ± € 1 ☐ Burial 2 Toremation 3 ☐ Removal from State ō permit. Page Department o Important: If any Injury or once. * 4 ☐ Donation 6 ☐ 9ther (Specify) 7-9-2004 Balto/Wash Crematory Laurel Maryland office of Emieral Service Lipensee Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of). MOWTH /Medical Examiner ARDIDMY OR ATM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by als mans PULMONANY DISBAJE 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) hos pull 1 Yes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE, (van h 301 51 BACINONE MD 2125 31. Date filed 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JŰĽŸ 9, 2004 Year Κ. LIBBY LEVENSTEIN 12:50 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE Months Days Hours Min. 8. Date of Birth Months Days Hours Min. Months 22, 1915 5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 212-09-0766 88 Yrs.

Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed

	Usual Residence of	f Decedent							ļ		
Usual Residence of Decedent 10a. State 10b. County MD BALT 10e. Street and Number 16 OLD COURT ROA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last, JOSEPH 19a. Informant's Name/Relationship (DONALD LEVENSTEI 20a. Method of Disposition 1 Widenial 2 Cremation 3 Decedent 4 Donation 5 Other (Specify Specify Specify Secondary Seconda		10c. City, Tow	n or Location				10d. lr	side City Limits			
	MD	BALT	TIMORE	[E	BALTIMORE				1	☐ Yes 2 🕅 No	
řě	10e. Street and Nu	mber			10g. Citizen of	What Country?					
a D	16 OLD	BALTIMORE et and Number OLD COURT ROAD #618 al Status lever Married 2 Married Vidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) ntary/Secondary (0-12) r's Name (First, Middle, Last) SEPH rmant's Name/Relationship (Type, Print) IALD LEVENSTEIN / SON and of Disposition Burial 2 Cremation 3 Removal from State Conation 5 Other (Specify) atture of Funeral Service Licepsed			21208			U.S.A.			
Funeral	11. Marital Status		12. Was Deceden		in U,S. 13. Was Decedent of Hispanic Origin? (Specify Yes				ce - American Inc	dian,	
						uban, Mexican, Puè	rto Rican, etc.)	Bla	ick, White, etc.	. T.C	
d by	3 X Widowed	4 Divorced	If Yes, Give Year or Dates:	If Yes, Give 1 ☐ Yes 2 🕅 No Specify: Year or Dates:				Specia	fy: WH	ITE	
lete		cify only highest gr	ducation a <i>de</i> co <i>mpleted)</i>	16a	Give kind of work dor	ne during most of w	orking	16b. Kind of B	Business/Industry		
Completed	Elementary/Seco	ondary (0.12) 12	College (1-4or	4or 5+) SECRETARY				AT LAW	V		
B		(First, Middle, Last)	18. Mother's Name (First, Middle, Maider.							
၉	JOSEPH				KLING	ELLA			GOLDST		
			** *		. Mailing Address <i>(Str</i> e)	
	20a. Method of Dis	position		20b. Place o	f Disposition (Name of ry, crematory or other p		Date		· City or Town, S	tate	
				9 .	EMUNAH) A]	,	7/11/04	BAL.	TIMORE,	MD	
	21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS.										
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
	23a. Part1. Enter t	he disease, or com rt failure. List only	plications that cause one cause on each I	d the death. Do	not enter the mode of d	ying, such as cardia	c or respiratory a	rrest,		oximate val Between	
	. 75. 6	· -		11	21- 7		4			t and Death	
	Immediate Cause disease or condition resulting in death)		a	and	Struck !	Jennen to	lu		Un	linewn	
- d	Due to (or as a consequence of):										
Examiner	Company to the ties are	Sequentially list conditions, Due to (or as a consequence of):									
	cause. Enter Unde	ny, leading to immediate									
lical	Cause (Disease or that initiated events resulting in death) I		c. Due to (or as a consequence of):								
Physician/Medical	Toodking in dealing i	d									
iclan	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death?										
hys	Part II. Othar signir		V			given in Part I.			ntributa to tha c		
by P	-	17 4	po thy	2			וו	Yas 2∟ No	3 Probably	4 ⊡/Unknow	
		1h	м	ila						opsy findings	
completed		101	no longo	ovillen	-a		peno	med?	available completion of death?	n of cause	
팃							101	′es 2⊠No	1 ☐ Yes	2□ No	
Be	25. Was case refer	ed to medical				26. Place of De	ath (Check only o		1		
2	examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient 3□ DOA	ther: 4 Nursing I	Home 5□Resid	lence 6 □Oth	er (Specify)		
	27. Manner of Death 1 ☑ Natural	n 5 □ Pending investigation	28a. Date of Inju (Month, Da		ime of 28c. Injury W			now injury occur		****	
ifica	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	28e. Place of Inj	ury - At home, fai	rm, street, factory, office		28f. Location /5	Street and Numb	er or Rural Route	Number.	
z S	4 🗆 Homicide		building, ef	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Tou			,	
edicai	29a. Certifier (Check only one)	1□ Certifying Phy 2□ Madical Exam	ysiclan: To the best linar: On the basis of and manner st	t examination and	death occurrad at the t for investigation, in my	ime, date and place opinion, death occu	e, and due to the durred at the time,	cause(s) and ma date and place,	inner as stated. and due to the ca	use(s)	
	29b. Signature and	title of certifier			29c. Licer	ise number		29d. Date signed	d (Month, Day, Y	9a <i>r)</i>	
	•	11	M	7)	D	2756	<i>C</i> ₁	715	1104		
	30. Name and addre	ess of person who o	completed cause of a		Type, Print)	2756 88 Gr	ene T	Kee Va	21 2	1208	
	31. Date filed (Mont	h, Day, Year)	32. Registr	ar's Signature			,	*			
ar	111	1 1 0 000		- 14							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month Day Year **Physician** 04 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner العام bout MD Elder Care If Under 24 Hrs. 7. Age (In yrs. last birthday) If I Inder 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country)
 unk **Funeral** Months Days 10M 20 F Hours Apr 9, 28449646 Director Usuel Residence of Decedent permit. Pagas 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mentel Hygiene. Important: if Itam 27 is marked other than "naturel", or items 23s or 28s-f show 10a. Stete 10b. County 10c. City. Town or Location 10d. inside City Limits Itam 27 is marked other than "naturel", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at MD Baltimore Randallstown 1 ☐ Yes 2X No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9109 Liberty Road 21133 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: black Be Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) truck driver transportation 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David McCain Farrah Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Queen Rodwell/friend 3604 Mohawk Avenue Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State injury or 4 □ Donetion 5 NOther (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Tur Baltimore, MD 21201 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Pert1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner the attanding physician and the for use as the bunal-transit Hospital or Attanding Physician: The law requires that the daath certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) within 24 hours after deeth.

To the Funerel Director: After this cartificete has been signed by the a complately filled in by the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probabiy 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1□ Yes 2 **→ N**б Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Nature 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) W 000 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

			1 - For State Registrar	State of Mary		artment o				iene	0 L	220	115
	Physic	ian	Decedent's Name (First, Middle, Last,						2. Date of Deat Month	Dav	Year	3. Time o	of Death
	/Medi	cal	Milton Merril			4h Cib. To			July 4,	2004		12:50) AM ^M
7	Exami	ner	4a. Facility Name (If not institution, give Joseph Richey				wn, or Location altimor			4c. County	of Death		
	Funeral	_	Social Security Number		yrs. last birthday)	If Under 1 Y	fear If Unde		8. Date of Birth		9. Birthi	place (State	or Foreian
т	Director		350-34-5481 ¹	Д М 2□F	60 Yrs.	Months D	ays Hours	Min.	8. Date of Birth (Month, Day, July 29	1943	I 111	ntry) inois	
	pur *		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or Lo	antine.							
	Aarylan show	ō	MD 10a. State Harford	10	Edgewoo							10d. Inside C 1 □ Yes	City Limits s 200 No
	the N	Funeral Director	10e. Street and Number			10f. Zip Co	ode		1	0g. Citizen of V	What Cour		-A-3110
	3a or	<u>=</u>	1207-B Edgewood R	oad			21040	,				my:	
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98	ours after death with the Maryla ral', or Items 23a or 28a-f shov Exeralret must be notified at	y Fu	1 Never Married 2 Married	1 ∐ Yes 2∭M No If Yes, Give		1 Tes, specify 1 □ Yes 2X			rican, etc.)	Specify	k, White,		
Ś	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examirer must be notified at	ed by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:				-				ite	
<u> </u>	in 72	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual O kind of work a DO NOT use re	iccupation Ione during mo etired)	ost of workin	ng	16b. Kind of Bu	isiness/In	dustry	
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<u>ya</u>		70	Milton Merril										ulik
Maryland 21215-0036	a sa		19a. Informant's Name/Relationship (Ty						Route Number,			Code)	
	1 an Heal em 2 thar		Tasha Merrill/dau		.w 1207 Ob. Place of Dispo	-B Edge	ewood R	load E	dgewood,			Channe	
Baltimore,	Se to		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	cemetery, crei	natory or other	r place)		200	20c. Location -	City or 10	wn, State	
Ħ	# E # # .		'4 □ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service License		. 22	2. Name and A	ddress of Faci	ility					
B	Depa Impo any ii		21. Signature of Funeral Service License	ade, Divect		tate Ai Baltimo	natomy	Board	655 W.	Baltim	ore	Street	-
			23a. Part1. Enter the disease, or complishock, a heart failure. List only or	cations that caused the	death. Do not ent	er the mode of	dying, such a	is cardiac or	respiratory arre	st,		Approximat Interval Bet	te
	Pnysician		Immediate Cause (Final disease or condition	Cance	er of the	large	· V				11	Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a co		10071					и	AN VIO	,011
		7	Sequentially list conditions,	Due to (or as a co	nsequence of):								
	t f unsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 (0) (4) 43 4 00	risoquarico oi).						- 1		
oʻ	be exacuted sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):								
8760,	ate be exacuted hysician and the burial-transit	ledical		i									
9	artifica ing ph na as tl	Med	IF FEMALE:				118						
Вох	death certifica e attending ph ed for usa as t	ian/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregn				23d. Date Mon	of delive	,	Year
o.		Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specif)	y)			10.00		Juy .	rour
σ,	res that the ignad by th be detache	by Ph	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying cause	e given in Part	1.	23e. Did tob	acco use contri	bute to th	e cause of d	ieath?
Vital Records	requires neen sign hould be								1 ☐ Yes	s 2 □ No	3 Prob	abiy 4 □U	Jnknown
000	aw S S	ompleted							24a. Was an		/ere autor	psy findings	available
Ä	The ate h page	Com							autopsy perform	ed2 de	eath?	nptetion of ca	ause of
/ita	ysiclan: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Plac	e of Death	(Check only one			20110	
of \		2	1 ☐ Yes 2 No		2 ER/Outpatien	1 JE DON			e 5 🗆 Resider		r (Specify	1 020	ce
	ding f h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury		Injury at Work? 1 □ Yes 2 □		3d. Describe how	v injury occurre	ed	,	
Division	or Attending after death. Director: After In by the fune	fica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, str				3f. Location (Stre	eet and Numbe	r or Rural	Route Num	hor
á	af or a after	Certification	4 Homicide	building, etc. (Sp	pecify)	,,,			City or Town,	State)	, 0, 110,01	710010 74077	J61,
	ospit hours unera ly fille		29a. Certifier (Check only 2 Medical Examin	sician: To the best of my	/ knowledge, death	occurred at th	ne time, date a	ind place, ar	nd due to the car	use(s) and man	ner as sta	ated.	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	fedical		ner: On the basis of examination and manner stated.	mination and/or inv			ath occurre)
	with Con	Σ	29b. Signature and title of certifier				ense number		29	d. Date signed	(Month, E	lay, Year)	
,	(1)		Uso M)		V	2417	10		July :	5,2	4004	
(4		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print) X2 &	NE	+	St Bu	16	n M	0 74	201
	⊱Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	11021	- 0 70	· U	u aw	11 100	LITT MOY	C1-1	· V 214	-01
	Registr	ar	JUL 1 3 20	004	. 12 1	land o	ù.						

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Milton E. Merrill, II

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Larry Gene Mabe <u>1:</u>08 ам 2004 July 12,_ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2400 Holly Neck Rd. Essex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 2,1941 Birthplece (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs North Carolina Director 220 36 2053 63 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exercises must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2400 Holly Neck Rd. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer Steel Mill 9 iii. Pages 1 and 2 should be filed variment of Health and Mental Hygie brtent: If item 27 is marked other tinjury or other traumatic event. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unk. Pharie Mabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Alice Mabe (Wife) 2400 Holly Neck Rd. Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department Importent: hany injury o *4 □ Donation 5 □ Other (Specify) Bayview Crematory 7/12/2004 Baltimore, Maryland 21. Sign to re p) Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, 23a. Pair1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** melanoma SPAVS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in juny that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. P ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2X No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA SIL 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. complately (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title/of 29d. Date signed (Month, Day, Year) 0 death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

		1 - For State Registrar	State of Maryla		artment of He rtificate of D			iene eg. No. 004	22017	
Physici /Medi		Decedent's Name (First, Middle, Last	Doris	L.	Marshal	1	2. Date of Dear	_	3. Time of Death	
Examir Funeral Director		4a. Facility Name (If not institution, give Franklin Square Ita 5. Social Security Number 6. Se 214-20-1331	spital Center	s. <i>last birthday)</i> Yrs.		ocation of Deat If Under 24 Hrs Hours Min.	. 8. Date of Birth	4c. County of E Ba Hi (Year) 9. (1918 1		
Marylatiid XIX 13-0030 Id 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hyglene. 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Exantinar must be rediffed at		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo								
	Director	Maryland Bal 10e. Street and Number	timore		10f. Zip Code			10g. Citizen of What Country? United States		
	by Funeral	7840 Denton Ave 11. Marital Status 1 Never Married 2 Married 35247/idowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban,	21219 vanic Origin? (S Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - /	American Indian, White, etc. White	
	Completed b	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	dent's Usual Occupati kind of work done dui DO NOT use retired)	ring most of wo	rking		St. Kind of Business/Industry Steel Industry	
	To Be Co	8 Years 17. Father's Name (First, Middle, Last) John Norr		7		8. Mother's Na	me (First, Middle, I		Industry	
		19a. Informant's Name/Relationship (T. Mr. Allen L. Ashv	ell/Grandson	784	ng Address (Street and O Denton A		gemere, M	laryland	21219	
oermit. Pages 1 ar Department of Hea mportent: If item 3 any injury or other ance.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place) 20c. Location - City of cemetary, crematory or other place)								
permit Depar Impor any in		21. Sign ure of Funeral Service Licens 29.2 Part Lenter the disease, or comp	· Can		Ouda-Ruck 1 922 Wise A	Tuneral	oundalk,	Maryland	Inc. 21222 Approximate	
/Medical Examiner Sphysician and streep by the purial-transit in	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a const	equence of):	bus	nty io	chemia		Onset and Death	
that the death certificed by the attending I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of Month	delivery Day Year	
law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause given	in Part I.	23e. Did tob		te to the cause of death? Probably 4 □Unknown	
The ate h page	Completed						24a. Was a autops perform	v prior		
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	Other		ath (Check only on		Spacify)	
Pe Te		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury a Work?	t	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred		эрвигу	
To the Hospital or Attendition 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spe	cify)			City or Town	n, State)	r Rural Route Number,	
n 24 hol n 24 hol ne Fune	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the time, vestigation, in my opir	date and place ion, death occi	e, and due to the caurred at the time, do	ause(s) and manne ate and place, and	r as stated. due to the cause(s)	
To the within To the comp	Me	29b. Signature and title of certifier	Wang		29c. License r AT24	_	16-020	9d. Date signed (M	4	
5		30. Name and address of person who co	ng 9000 Fro	inklin	Print) Square	Drive	Baltim	ore, Md	21237	
St Regist	ate rar	31. Date filed (Month Pay, Year 3 2	32. Registrar's Sig	nature	han .			,		

			1 - For State Registrar		State of	Marylaı	nd / Depa	artmen rtificat				lental Hy	gier Reg. N	0.0	04	2201	Ω
	Physic	an	Decedent's Name (First, Midd	le, Lest)								2. Date of De Month)ay	Year	3. Time of Deat	th
	/Medi		Betty M.	Mei								July		9	2004	3:10 1	M
4	Examir	ner	4a. Fecility Name (If not institution	. •				4b. City,	Town, or	Location o			4	c. Count	y of Death		
			Union Memoria					If I Indo	4 Vaar	Balt		_			N/A		
	Funeral Director		5. Social Security Number 214-12-1506 Usual Residence of Decedent	6. Sex 1 ☐ M	4 2X) F	92	. last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bi (Month, Da June 2	th 1 <i>y</i> , Yea 7 , 1	912	9. Birthp Cour Mo	lace (State or For viry) Vryland	eign
	land		10a. State 10b. County	,		10c. C	ity, Town or Lo	cation							1	0d. Inside City Lin	nits
	filed within 72 hours after death with the Maryland Hygiene. uther than "neturel", or items 23a or 28a-f show ont, the Modical Examinar must be notified at	Funeral Director	Maryland	N/A					Balt	imore	2					1X Yes 2□	
	with ti	吉	10e. Street and Number					10f. Zip					10g. C		What Coun	•	
	s 23s	ra	4211 Shamrock							206					S. A		
	er de Items	nue	11. Marital Status		. Was Deced Armed Ford	ces?	J.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))-		ce - Americ ick, White,		
36	rs aft	J. F	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorce		1 ☐ Yes 2 If Yes, Give Year or Dat	•		1 ☐ Yes	2 X No	Specify:				Speci	ty: Whi	+0	
Ö	thou sture	ed	15. Deceder				16a. Dece	ient's Usua	al Occurs	ation.			16h	Kind of F	Business/Inc		
21215-0036	in 72	Completed by	(Specify only highe	st grade d	completed)		(Give	kind of wo	rk done d	luring most)	of worki	ing	100.	KING OF E	ousiness/inc	lustry	
212	filed with Hygiene. ther than	Eo	Elementary/Secondary (0-12) 12thGrade		College (1-	4or 5+)				emake				С	wn Ho	me	
b	filled I Hyg othe	BeC	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Middle	, Maide				
<u>a</u>	Mental Merked o	To B	Pasquale Mar	tini					ļ			Carmell	a s	anto	L		
Maryland	2 should be filed within 72 hours after death w and Mental Hygiene. Is marked other than "neturel", or items 23a eumatic event, the Modical Experies must		19a. Informant's Name/Relation:	hip (Type	, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City	or Town	, State, Zip	Code)	
	1 and 2 Health a em 27 is		Robert Meier	(Son)			4211	Sham	rock	Aver	we,	Baltim	ore	, Md	. 212	06	
J.	ss 1 and of Health item 27		20a. Method of Disposition			20b.	Place of Dispo	sition (Nan	ne of ther place	9)	0	ate	20c.	Location	- City or To	wn, State	
E	Pages nent of H ont; If ite		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (\$		noval from Si		vrdens				/12/	2004	Bal	timo	re. M	aryland	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, Item 2006.		21. Signature of Funeral Service	Liggrisge	= (22	. Name an	d Addres	s of Facility	Sch	imunek Baltimo	Fun	eral	Home	s	
			23a Part1. Enter the disease, o	complica	tions that car	used the dea								Mari	grana	Anproximate	
	al House	8	Immediate Cause (Final	only one	cause on ea	ch line.				,		,				Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a		PS/S	auonaa att				_				-		
	Examiner				249 10 (0)	1 43 4 CO11360	querice ory.										
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (o	r as a consec	quence of):						_		-		
	be executed sician and burial-transit	Examiner	cause. Enter Underlying that initiated events	S													
ó	exection and and rial-tr	Exa	resulting in death) Last	C.	Due to (o	ras a consec	quence of):										
8760,	cate be ex hysician the buria	Physiclan/Medical		d.													
9	tifica ig ph as th	ed		-													
Box	th certific tending p	N/C	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, outco	ome of pregn th 2 Peta		Cataniana						23d. Da	ite of delive	у	
	death e a te	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregnar	nt at time of o]Ectopic pr] Other (sp						Mo	onth	Day Year	
P.0	by the detached	hys	9 Dunknown		9□ Unknow	vn											
of Vital Records, F	The law requires that the death certificate be executed the has been signed by the atending physician and tage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditi	ons contri	buting to dea	th but not res	sulting in the ur	nderlying ca	ause give	n in Part I.				use con	-	a cause of death? ably 4 □Unkno	
CO	w require been si should I	Completed										24a. Was	an	24h	Were auton	sy findings availal	ble
Re	The lav	т								-		autor perfo	sy rmed?		prior to com death?	pletion of cause of	of
a		Ö	25. Was case referred to medica							00 Di	-4 D45		2 DM	0	1 ☐ Yes	2 🗓 No	
Ē	Physicien: this certific ral director,	To B	examiner?		pital:	nationt 2	ER/Outpatien	3 DO	. Othe			Check on a		a Clou	(0)		
of	Phy er this eral c		27. Manner of Death		28a. Date of	Injury	28b. Time of		8c. Injury Work	at Nur	sing non	l8d. Describe I	ow inju	ny occur	ier (<i>Specity,</i> red		-
lon	ith. ; After s funer	I lo	1 Natural 5 Pendii 2 Accident investi		(Month,	Day Year)	Injury	М		? 'es 2 □ N							
Division	Attencer death	Certification;	3 ☐ Suicide 6 ☐ Could	not be	28e. Place o	f Injury - At h	ome, farm, stre	et, factory	, office		2	8f. Location (S	Street a	nd Numt	per or Rural	Route Number,	_
<u>S</u>	after after Dire	erti	4 Homicide	illied	building	, etc. (Speci	ty)	,	,			City or Tov	n, Stat	Θ)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; Atter completely filled in by the funer	edical C	29a. Certifier 11 Certifyin (Check only one) 2 Medicel	g Physici Examiner	ian: To the b	is of examina	owledge, death ation and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	nd due to the	cause(s	and ma	anner as sta	ited. the cause(s)	
	o the ithin o the smple	Med	29b. Signature and title of certifie	r	und mainle	. stateu.		29c	. License	number			29d. Da	ate signe	d (Month, D	lav. Year)	
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•	di		30. Name and address of person	week-	D'U	of doath /lt	n 22a) /Tune 1		127	4389	76			July	19,2	004	
	1.			wrio comp						C II.		A		0			
	Sta	te	Elliot Share P. O. 31. Date filed (Month, Day, Year,		_	gistrar's Signa	ature	Soo	vay	Baltin	nore;	/no 2	12/	6			
	Registr	-	31. Date filed (Month, Day, Year,	2004	St	we	B	100	de	/							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) 12:00 nom Month 2004 MACE Physician DATRICIA 9 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. B. Date of Birth Jan. 13, Year) 9. Birthplace (St. Country) Mary Land 5. Social Security Number 219-42-229 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 86 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State itam 27 is marked other than "natural", or Items 23a or 28s-1 ahow other traumatic avant, the Madical Examinar must be notified at Owings Mills Maryland Baltimore 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8815 McDonogh Road 21117 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Ind Mental Walter Albert Patrick Millicent Gertrude Leach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 st ment of Health and tant: If item 27 is r Carroll Mace Daughter 2828 Egypt Road Apt 103K Norristown, PA 19403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore-Washington 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or 7/13/2004 1 4 □ Donation Crematory //13/2004 Laurer, Fia
22. Name and Address of Facility
Burvee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland Laurel, Maryland 21. Signature of Funeral Service Licenses 21211 m Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PSIS DOYS **Physician** /Medical Due to (or as a consequence of) INTRAABOD MINAL VISCUS **Examiner** -RF0120+1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-transit death certificate be executed and Due to (or as a consequence of): attending physicien for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Cardiomyopathy action M 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? page 2 certificate 1 Yes 2 - No in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: : After I 5 Pending investigation 4- Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Puneral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Prin resher Hospital Kamerwan 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

	•	FOI	partment of Health and Mertificate of Death		ene a. N. O. O. L.	22020
		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	n Day Yea	3. Time of Death
Physicia /Medica		FRANK XAVIER MORAN		JULY	3 200	A
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	eath
		FREDERICK MEMORIAL HOSPITAL	FREDERICK		FREDER	
Funeral		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthda 1 M 2 □ F	Months Days Hours Min.	 Date of Birth (Month, Day, 	Year) 9. E	irthplace (State or Foreig Country)
Director		213-36-1409 123 M 2		May 20,	1939 Ma	ryland
land ow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limit
-f sh	ţō	Maryalnd Frederick New 1	Market			1 ☐ Yes 2 📉 N
r 28e	rec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What	Country?
72 hours after death with the Maryland 72 hours after death with the Maryland naturel', or Items 23a or 28e-f show 115al Exprired roust to notified at	Funeral Director	5731 01d Log Court	21774		U.S.A.	
deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, W	nerican Indian,
or its	T.	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 No Specify:	1110211, 610.7	Specific	
ural'.	Completed by	3 Widowed 4 Divorced Year or Dates:			Specify: W	hite
72 h	ete	15. Decedent's Education (Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired)	ng 1	6b. Kind of Busines	ss/Industry
then the Market	d m	Elementary/Secondary (0-12) College (1-4or 5+)	ctor of Research		Medicine	
Hygie ther	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M		
Mary Jane 21215-0050 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "naturel", or traumatic event, the Madical Expir	o Be	Francis L. Moran	Mary B.		,	
shoul mari	ဥ		ling Address (Street and Number or Rura		City or Town, State	, Zip Code)
IVIC 11th ar 127 is 1 trau		Mary Jeanne Moran (Wife) 573	l Old Log Court New	Market.	MD 2177	4
tem Head		20a. Method of Disposition 20b. Place of Dis			Oc. Location - City	
Page ent o nt: If			sh Cemetery 7-10-	04 L	aurel, Ma	rvland
pallithory, Mal yiallo ZIZIS-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinating the malified at once.		21. Signature of Funeral Service Licensee _ / /	22. Name and Address of Facility Vitzke Funeral Home 1630 Edmondson Aven			•
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
Pnysician /Medical Examiner			THE INFARCTION			21024
TOTAL .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cleeces Jerryury that initiated events c.				
fou, te be executed ysician and te burial-transit	cai Exar	that initiated events resulting in death) Last Due to (or as a consequence of): d.				
certificat reding physee as the						
death death e atter	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of o Month	lelivery Day Year
w requires that the speen signed by the should be detached.	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
quire no sign and blud b	pe pe	LARYNGTAL CANCER		1 ☐ Yes	s 2 ⊠ No 3□	Probably 4 □Unknow
he taw he taw s has b	Completed	SLEEP JEWEN		24a. Was an autopsy perform	ed? death	autopsy findings available completion of cause of 2 No
sician: Th sician: Th certificate irector, pag	0	25. Was case referred to medical	26. Place of Death			
Physician: this certific ral director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ent 3 DOA Other: 4 Nursing Hor	me 5 Resider	nce 6 Other (S)	necify)
After Tune		27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	w injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
the Hospital in 24 hours in 24 hours in pletely filled	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, de 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	and due to the car ed at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mo	nth, Day, Year)
			D32171		7/3/	04
10		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)			
l l			BOX 328 WALKUR	SULLE	mo 21	793
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

umpend item#23a,27,28a-f,PER ME,G833,7/27/04eg Teresa Mackey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 4487State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar **AKG** Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Teresa J. Mackey 11:27P M July 8, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 M 2 F Director Yrs 216-76-5550 46 Sept. 20, 1957 Maryland Usual Residence of Decedent the Maryland 10a. State 10h Counts 10c. City, Town or Location item 27 is markad othar than "natural", or itams 23a or 28a-f ahow othar traumatic event, if a Medical Enacinari francisca 10d. Inside City Limits Maryland N/ADirector Baltimore 1 ▼ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 Greenmount Avenue 21218 USA death y 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene. Is markad othar than "natural", or Ital Black, White, etc. TXNever Married 2 ☐ Married Baltimore, Marvland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Freelance Consultant Computer Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John R. Mackey Mary L. Brayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sment of Health an John R. Mackey Father 7983 Glenbrooke Lane, Sarasota, Florida 34243 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Commetery, crematory or other place)
Baltimore-Washington 7/13/2004 Laural, Maryland 1 ☐ Burial 2 🙀 remation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Crematery 22. Name and Address of Facility 21. Signature of Funeral Service Lice Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lowerdate Council (First). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cocaine and Oxycodone Inotxication **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. 3 U. Co., cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the Se IF FEMALE: ase i 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 🗆 No Yes 2□ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ Propertient 3 ☐ DOA 2 1 XYes 2 □ No this 28a. Date of Injury 28b. Time of found 17/8/04ar) found 10:30p 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 🗷 No investigation 2 Accident Director; in by the Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide filled found at home within 24 hours a To the Funeral D 3900 Greenmount Ave., Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 9, 2004 lame and address of person who completed cause of geath (Item 23a) (Type, Print) III Pen Street Baltings, MD 21201 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

				partment of Health and Mertificate of Death	Mental Hygiei	0001 -
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) Charles G. Messersch		July	Day Year 3. Time of Death 9 2804 1504 M
	Examir Funeral	ier	4a. Facility Name (If not institution, give street and number) North Aruwse (1650) 5. Social Security Number (6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Ofen Burk If Under 1 Year If Under 24 Hrs.	ice	4c. County of Peath 9. Birthplace (State or Foreign Country)
	Director		214 20 9354 1 M 2 F 76 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 26,	1928 Maryland
	death with the Maryland rms 23a or 28a-f show rust be retified at	Director	Maryland Anne Arundel Baltime	ore		1 ☐ Yes 2X No
	ath with t		10e. Street and Number 127 Cedar Hill Road	10f. Zip Code 21225	10g.	Citizen of What Country?
9036	ours after ral', or Ita	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1. ∑Yes 2 □ No If Yes, Give WW II	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	l within 72 iene. r than "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Chinist	ing N	Kind of Business/Industry Vational American Can Company
land	od a p	To Be C	17. Father's Name (First, Middle, Last) John Messerschmidt	18. Mother's Name	e (First, Middle, Maid	den Sumame)
Mary	s 1 and 2 should f Health and Mer itam 27 Is marka othar traumatic	-		ling Address (Street and Number or Rura Cedar Hill Road	al Route Number, Cit	y or Town, State, Zip Code)
Baltimore,	00-		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, critical contents of the complex of the com	position (Name of Ematory or other place)	Date 20c.	Ce, Maryland 21225 Location - City or Town, State malk Hill, Penna.
Balti	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee Jerome Framwourth 4	22. Name and Address of Facility Gor 001 Ritchie Highwa	nce Funera Y Baltir	al Service, P.A. more, Maryland 21225
	Priyaician /Medical Examiner	Examiner	23a. Part 1. Enter the disease for complications that caused the death. Do not expected a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	1/		Approximate Interval Between Onset and Death
.O. Box 68760,	death certificate e attending phys d for use as the	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	w requires that the d been signed by the should be detached		Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacce	o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	The law ate has b page 2 st	Completed by			24a. Was an autopsy performed?	
of Vit	S 0 =	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie			6 □Other (Specify)
Division o	ng After	Certification;	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 5 Could not be determined 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rural Route Number,
Ō	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	City or Town, Sta	(s) and manner as stated
	To the Ho within 24 I To the Fu completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or is and manner stated. 29b. Signature and title of certifier Deputy	vestigation, in my opinion, death occurred	ed at the time, date a	nd place, and due to the cause(s) Date signed (Month, Day, Year)
	VI		Millian P. gono, mo	1		1. 21035
	771		30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature	695 Am	erica (A. 21035
*** ****	Sta Registr	31	31. Date filed (Month, Day, Year) 32. Registrar's Signature	W		

			partment of Health and Mertificate of Death	lental Hygie	3
° Phys		Decedent's Name (First, Middle, Last) Mary Emily Nowak		2. Date of Death Month	Day Yeer 3. Time of Death
	dical		4b. City, Town, or Location of Death	July 8,	
Exan	niner	Genesis Heritage Meridian Eldercare		l k	4c. County of Death Baltimore Co.
Funer Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 218-10-4380 1 M 2 F 84 Yrs.		8. Date of Birth (Month, Day, Y June 29,	9. Birthplace (State or Foreign
Baltimore, Imaryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23c or 28a-f show eny injury or other treumatic event, I're Medical Examinations.	ector	Usual Residence of Decedent 10a. State		ındalk	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
3s or	Ö	8223 Bear Creek Drive	21222		Citizen of What Country? Inited States
s after death or Items 2	y Funeral Director		3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: The dec
Fire i	d b	3 ☑ Widowed 4 □ Divorced Year or Dates:			White
21215-0036 Id within 72 hours aft giene. or then "naturel; or it e Medical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of workil . DO NOT use retired)	ng 16	b. Kind of Business/Industry
Hygir Hygir			Homemaker 18. Mother's Name	(First Middle Ma	Own Home
Maryland od 2 should be file th and Mental H; tre marked oth treumatic event	To Be	Michael Maszczenski	Eva Tark	oski	, ,
n Wiar and 2 sh salth and alth and ar treum		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma Timothy E. Nowak / Son 110	iling Address (<i>Street and Number or Rur</i> a Bayside Drive Dur	<i>l R</i> oute <i>Number, C</i> ndalk , Ma	ity or Town, State, Zip Code) ryland 21222
Saltimore, bernit. Pages 1 at Department of Hea mportent: If item any injury or othe		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition state 20c. Place of Disposition cemetery, cr	position (Name of Dematory or other place)	ate 200	c. Location - City or Town, State
Fag tment tent:		`4 □Donation 5 □Other (Specify) Holy RO	sary Cemetery 7/12/	'2004 D	undalk, Maryland
Departiment Departiment Importion only in	SUCE		22. Name and Address of Facility uda - Ruck Funeral Ho 922 Wise Ave. Dund		
te be executed /Medica Examine e bruial-transit	il .	23a. Pan1. Enter the disase, or complications that caused the death. Do not e shock, or heart failure. Liet only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Securitary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Y PYEYMON		Onset and Death
	ical	d. HYPERTEN	1510K		
death certif	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
us, r luires that n signed b	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
iclen: The law requires that the certificate has been signed by th rector, page 2 should be detache.	Completed	DEMENTA		24a. Was an autopsy performed	
ng Phys fter this	atlon: To Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of eath	of 28c. Injury at 2		e 6 □Other (Specify)
tal or Attending rs after death. el Diractor: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (Street City or Town, St	t and Number or Rural Route Number, late)
To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal Medicel Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and occurred at the time, date and place, and occurred the control of	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To t To t	×	29b. Signature and title of certifier	29c. License number D 29/61	29d.	Date signed (Month, Day, Year)
10		30. Name and address of pers in who com leted cause of death (it in 23a) yee	Print) Print) Print	81:6	VIOR NO TOS
S Regis	tate trar	31. Date filed (Mopth, Day Year)	dones		1411 5111 21 160

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Vaar **Physician** Eleanor L. 0wens 7:30 a. July 9 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Lutherville Baltimore Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Yo Feb. 20, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Year, 1 M 2 XF 81 Yrs Feb. 218-14-6196 1923 Director Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercit or must be inclined at 1 ☐ Yes 2 No Director Maryland Baltimore Co. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 202 2418 Chetwood Circle 21093 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. e filed within 72 hours after all Hygiene.
other than "natural", or Ital 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Hairstylist Beautician permit. Peges 1 and 2 should be the Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event socie. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Burdette Schwartz Henry Lottie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Son Mr. Ronald C. Owens 3003 Beason Court Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Oak Lawn Cemetery July 13, 2004 Baltimore, MD 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician bulmonar ardio /Medical Due to (or as a consequence of): Examiner runni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 28 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🐹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nay 231005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUKHNO MO DIDOCKAR MDBAIN 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	arylar	•			lealth ai Death	nd M	ental Hy	giene	001	22025	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05 NTONIE 600 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death **Examiner** VINDALE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month 7. Age (In yrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F 212-30-2030 Usual Residence of Decedent Yrs. Director e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or Items 23s or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner: sist be notified at 1X Yes 2 □ No Funeral Director MARILAND 10g. ditizen of What Country? 10e. Street and Number USA. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 ♠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VR5 RINCIPAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If item 27 ie marked o any injury or other traumatic eve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MONTICELLO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial Cremation 3 Removal from State 1 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licel, le BALTO, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** ensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examine physician a s the burial-Physician/Medical as use : IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 🗌 Yes 2 🗀 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Magner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Division To the Hospital or Attending

Certification:

within 24 hours after death To the Funeral Director:

29a. Certifier Medicai 29b. Signature and title of certified

Registrar

31. Date filed (Month, Day, Year) 3 2004

3 🗌 Suicide

4 🗀 Homicide

(Check only one)

30. Name and address

5 Pending

investigation

6 Could not be determined

170 32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magney stated.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		1. Decedent's Name (First, Mid				rtificate of			2. Date of Dea	Reg. Np.	J () 3-3	19 5 1.0
nysician	1			hillina					Month	Day	Year	3. Time of D
Medical xaminer		Adam Chri				4b. City, Town, o	or Location	of Death	JULY		2004 ounty of Death	
xammer		ST.AGNES HO		,			IMORE		Ž.			
neral ector		5. Social Security Number 216-25-2254	6. Sex 1 ☑ M 2 ☐ I		rs. last birthday) 14 Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Aug. 20	, Year) , 1989	Cou	place (State or F ntry) vland
24	-	Usual Residence of Decedent 10a. State 10b. Coun	ntv	10c. (City, Town or Lo	ocation						10d. Inside City
led at	_		timore		Catons							1 ☐ Yes 2
ke notifie Director	- E	10e. Street and Number			- Carono	10f. Zip Code				10g. Citizen	n of What Cou	ntry?
al D	ב ב	405 Bathurs	st Road				21228	3		U	.S.A.	
Exerting roust be redified at by Funeral Director	2	11. Marital Status 1 🛱 Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	Armed 1 ☐ Ye If Yes,	Decedent Ever in I Forces? es 2 🖾 No Give or Dates:		Was Decedent of HIF Yes, specify Cub			ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify:	
or other traumatic evant, the Medical Exp	beled	15. Decede (Specify only high Elementary/Secondary (0-12	ent's Education hest grade complete	ed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	ation during mos d)	it of work	ing	16b. Kind	of Business/In	dustry
Con	5	8			S	tudent	,				ducatio	on
evan Be	De	17. Father's Name (First, Middl							e (First, Middle,		mame)	
matic		Timothy O. Pl 19a. Informant's Name/Relation	-		10h Maili	ng Address (Street			hillips		Dum Ctata 7'	Cadal
rtrau		Sharon Phillip		Mother)	1	Bathurst						
or other	3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	n 3 Removal fro	20b om State	. Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce)	(Date	20c. Locati	ion - City or To	own, State
any injury o once.	-	*4 □ Donation 5 □ Other 21. Signature of Funeral Service		G G		pherd Cem				Ellic	ott Ci	ty, Mar
any		VV2	011	many	/-, W	itzke Fun	era1	Home	of Cat	onsvi	lle, Ir	nc.
cian dical niner		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due		osis co	2. Name and Addre itzke Fun 630 Edmon Her the mode of dyin mplicatin	ng, such as	cardiac c	or respiratory arr	est,		Approximate Interval Between
dical liner		Immediate Cause (Final disease or condition	a. Due	to (or as a cons	osis co equence of):	ter the mode of dyir	ng, such as	cardiac c	or respiratory arr	est,		Approximate Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 ear Physician July Leslie R. Pashkow 11, 7:55p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | 9 | Month | Day | Year | 9 | 15 - 1 | 9 | 58 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F New York 086-48-8111 45 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 Mo Funeral Director MD Baltimore Co. Lutherville 10e. Street and Number 10a. Citizen of What Country? 10f. Zin Code 11702 Falls Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 😭 Married Maryland 21215-0036 Completed by Specify:White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nurse Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other ary injury or other traumatic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leonard Pashkow Dolores Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allen Polansky-Husband 1416 W. Mt. Royal Ave. Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Bayview Crematory 7-12-04 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, 21. Signature of Funeral Service Censes 1201 Dundalk Ave. Baltimore, MD 21222 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monters MUNISMIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day YHAR 5 ☐ Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **W**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attanding Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPICE 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certurying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier D hada 87 Deltammemo 21200 gerson who completed cause of death (Item 23a) (Type, Print) 6601 revies mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 1 3 2004

				Please	Type or Print in	Black Inde	lible Ink. Ensur	e All Copies A	re Legible.	
3				1 - For State Registrar		nd / Depart	ment of Health ar	d Mental Hygi		22031
		Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, L. ALGIRDAS 4a. Facility Name (If not institution, gi	J. RIMA Ver street and number) HESP, tel	(EVICIUS	D. City, Town, or Location of Discharge Types If Under 24	2. Date of Death Month Death Hrs. 8. Date of Birth	Day Year Year 4c. County of Deal Que Rink	3. Time of Death 7:45 P. M Thouas (State or Foreign
0710170		Director	Director	Usual Residence of Decedent 10a. State 10b. County Md. Anne Ar 10e. Street and Number	undel Co. G	ity, Town or Location	on	Min. (Month, Day, 1) June 26	rear) Co	thuania 10d. Inside City Limits 1 Yes 2 No
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	5-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If flem 27 is marked other than "neturel; or flems 23a or 28e-1 show or other treumatic event, the Madical Examiner ⊓ust be notified at	d by Funeral Director	7607 Turnbrook 11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:	lf Ye	21060 Decedent of Hispanic Origins, specify Cuban, Mexican, P Yes 212 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	U.S.A. 14. Race - Ame Black, White Specify: W	
	21215-	ad within 72 h /giene. er than "nett	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+) ()	(Give kind life. DO	s Usual Occupetion I of work done during most of NOT use retired) L1 Worker	Working	Sb. Kind of Business/ Cme Home Onstructio	
	Maryland 2121	hould be file d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last Joseph 19a. Informant's Name/Relationship	Rimkevicius	10h Maitin A		Name (First, Middle, Ma	u	nknown
		s 1 and 2 si f Health an Item 27 is n		Birute M. Rimkev	icius (Wife)	7607]	ddress (Street and Number of Curnbrook Driv	re, Glen Bu	City or Town, State, 2 rnie, Md.	21060
	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree		1 ☑ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	(fy) Me	L 22. Na	e Memorial Pk me and Address of Facility McCully-Polyn	iak Funeral	Home P.A.	
•		Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	th. Do not enter th	3204 Mountain e mode of dying, such as car	KOAD, PASA	dena, Md.	Approximate Interval Between Onset and Death
	68760,	Examment and we be executed which be burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerebrotz Due to (or as a consect Due to (or as a consect of d.	quence of):	_ accidente prulmon	ruy dise	age.	
	P.O. Box 68	The law requires that the death certificate be exeite has been signed by the attending physician are bage 2 should be detached for use as the burial-1	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of o	al death 3 □Ecto	opic pregnancy er (specify)		23d. Date of deliver Month	very Day Year
		w requires that s been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not res	sulting in the underl	ying cause given in Part I.	23e. Did tobac	2 □ No 3 Pro	
	al Records,	(0 -	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
. 1	Vital	icie: certii recto	Be	25. Was case referred to medical examiner?	Hospital:		Othor	Death (Check only one)		
X	of	Phy this	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at	g Home 5 Residence		fy)
	Division	ten teatl tor: the	Certification;	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	(Month, Day Year) n 28e. Place of Injury - At h	Injury Nome, farm, street, f	Work? 1 Yes 2 No	28f. Location (Stree	et and Number or Rui	al Route Number,
	Ō	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifying Pl	building, etc. (Special	owledge, death occ	urred at the time, date and pl	City or Town, S	State)	total d
		To the Hospital within 24 hours a To the Funerel I completely filled	Medical	one)	niner: On the basis of examina and manner stated.	ation and/or investig	pation, in my opinion, death o	ccurred at the time, date	and place, and due t	o the cause(s)
		To To	<	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month,	Day, Year)

To the Hosp within 24 hor To the Fune completely fi

State Registrar

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

July 11 200 4

11 2004

		ľ	State of Maryland / Department of Parks of Pa	artment of Health and Me /U4dnb tificate of Death	ntal Hygier	ne 2001. 22020
	ے Physici		1. Decedent's Name (First, Middle, Last) Frank A. Rowlette,	2	Date of Death Month	Day Year 7 2004 8:15 a M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 7133 Windsor Mill Road	4b. City, Town, or Location of Death Woodlawn		4c. County of Death Balto
	Funeral Director		5. Social Security Number 213-32-1635 6. Sex 1 № 2□ F 7. Age (In yrs. last birthday) 69 70 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Yea 7- 24-1	
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Balto Woodlawn			10d. Inside City Limits 1 ☐ Yes 2 No
	with the A	Funeral Director	10e. Street and Number 7133 Windsor Mill Road	10f. Zip Code 21244	10g. (Citizen of What Country? USA
336	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Marical Examinating the natified at	by Funera	Armed Forces? I	 Mas Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric I □ Yes 2 □ No Specify:	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	l within 72 hou iene. r than "nature the Medical E	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Maintenance		Kind of Business/Industry
Maryland 2	12 should be filed within 7 h and Mental Hygiene. 7 is marked othar than "' freumatic evant, It a M	To Be C	17. Father's Name (First, Middle, Last) Ralph E. Rowlette	18. Mother's Name (# Dora Har		en Sumame)
	1 and 2 show Health and N tam 27 is ma other traume		Dorothy M. Shields - Sister 7133	ng Address (Street and Number or Aural F B Windsor Mill Road		v or Town, State, Zip Code) wn, Md 21244
Baltimore,	Line Pe		Temporal 2 Defendation 3 Definition State	sition (Name of natory or other place) Drial Park 7-13-		Location - City or Town, State
Balt	permit. Departr Imports any Inji		Dyna DKete		enue Bal	Vest lto, Md 21215
	Pnysician /Medical	10 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or hear tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	1/4	espiratory arrest.	Approximate Interval Between Onset and Death
8760,	eate be executed my sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, reading to minimulate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last b. End Stes c. Canges Due to (or as a consequence of):	House and Arm	ellure	
O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	S G G	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	_	o use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown
I Records,	ician: The law requin certificate has been si rector, page 2 should I	Completed			24a. Was an autopsy performed?	
Vital	Physician: this certific ral director,	o Be (25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (C		
of	Jing After fune		1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Accident Inpatient 2 ☐ ER/Outpatient 2 ☐ ER/Outp	1 3 DOA 4 Nursing Home	5 X Residence I. Describe how in	6 □Other (Specify) ury occurred
Division	tal or Attandi s after death, al Diractor: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office 28f	Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invand manner stated.	restigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s)
	P with	2	29b. Signature and title of certifier	29c. License number 930115	29d. D	ate signed (Month, Day, Year)
	Ø		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print) 11 besty Hats r	tve Bal	+, mp 21215
ı	Sta Registi	-	31. Date filed (Month, Day, Year) JUL 1 3 2004 32. Registrar's Signature	books		

			For State Registrer	State of Ma	ryland				ealth a Death	ind Me		giene	004	22033
	Physicia /Medic		1. Decedent's Name (First, Middle, La	Dolores	Ann	Rei	đ				2. Date of Dea Month July 4	Day 200		3. Time of Death 10:50 P
	Examin		4a. Facility Name (If not institution, given Genesis Heritage 5. Social Security Number 6. S	Meridian	(In yrs. lasi	t hirthday)	D	Town, or Ounda r 1 Year	Location of 1k		8. Date of Birt	E		ore Co.
	Funeral Director			□M 2√2 F	72	Yrs.	Months		Hours	Min.	March	y, Year)	32 M	thplace (State or Foreign ountry) aryland
	e Marylan 8e-f show	Director		ltimore	10c. City, T	Town or Lo	cation			I	Dundalk			10d. Inside City Limits 1 ☐ Yes 2∑Ño
	with th	Dire	10e. Street and Number 7522 Old Battle	Trovo Pond			10f. Zip	Code	222				of What Co ed St.	•
98	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the men 21s cor 28e-f show at itiem 21s marked other then "naturel", or items 22s cor 28e-f show or other traumatic event, the Modical Examination and the notified at	/ Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give			Was Dece If Yes, spe	dent of Hi		jin? (Spec , Puerto R	cify Yes or No- tican, etc.)	. 14.		erican Indian, te, etc.
15-0036	"naturel",	Completed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's E (Specify only highest gra	Year or Dates:		16a. Dece	dent's Usu kind of wo	al Occupa	ation during most	of workin	g		of Business	White
2121	filed within Hygiene.	ошо	Elementary/Secondary (0-12) 12 Years	College (1-4or 5	+)		<i>во мот и</i> ion Р		" dent :	Local	1 738	Mart	in Ma	rietta
Maryland 2	2 should ba filed vand Mental Hygie Is marked othar is aumatic event, It	To Be C	17. Father's Name (First, Middle, Last Peter Cellante								(First, Middle, et Mews		mame)	
	1 and 2 shou Health and M lem 27 Is ma other traums		19a. Informant's Name/Relationship (Route Numbe e Road			Zip Code) Maryland
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Balti	permit. Pag Department Important: I any njury o		21. Signature of Funeral Privice Lice	Mass	us						Home of			Inc. 21222
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause in each lir a	the death. ne. a consequer								RE-	Approximate Interval Between Onset and Death
8760,	ite be axecuted iysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d. Due to (or a) d. Due	a consequer	IUF.	SZ 1 19 Ma	KU VEL TI	(T/) 8 R T 1 T U	EA FA	LENY 120 K	0 E	SEA	Q.
.O. Box 68	ne death certific the attending p hed for use as	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic p					230	I. Date of de Month	livery Day Year
rds, P.	quires that the signed by ald be detacted	d by Pr	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the u	nderlying	cause give	en in Part I.			obacco use /es 2 🗆 N		o the cause of death?
I Records,	The law requir ate has been sl page 2 should	Complete											24b. Were at prior to death?	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe Othe	or I		(Check only o			
of	ling After fune	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	v 28	VOutpatier 8b. Time o Injury		28c. Injury Work	at Nur	2	ne 5 Resid			cify)
Division	ial or Attendi s after death.	Certification:	3 Suicide 6 Could not to determined		ury - At home c. (Specify)	e, farm, sti	reet, factor	y, office		2	8f. Location (S City or Tox	Street and N m, State)	lumber or R	ural Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	edical		nysicien: To the best miner: On the basis of and manner sta	examination									
)	withi com	2	29b. Signature and title of certifier	& Field	1,	11)	29	c. License 2	number	5		29d. Date s	igned (Mont	th, Day, Year)
	5		30. Name and address of person who	completed cause of d	eath (Item 2)	3a) (Type,	Place		Dun	lak	MD	2)	22_	
	Sta Registr		31. Date filed Jour, Day, 3 200	32. Registr	ar's Signatur	L	do	also	,			181		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 A. M uchard TUI /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner HARFORD Stea Bel Air.

If Under 1 Year | If Under 24 Hrs. Brightvieu IVINO Date of Birth (Month, Day, Yeer) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 212-16-333 Usuel Residence of Deceden 1□M 20 F Director VICa with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show traumatic event. The Medical Examiner must be notified at 1 ☐ Yes 2 No HARFORD Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 W 21014. tactor Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. satt: If item 27 is marked other than "natural", or Itema 23 Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) FRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health : 21014 other 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gardens 1-10-04 22. Name and Address of Facility 21. Signature of Funeral Service L PORT DR, FOREST HILL, MI CHAPEC EVAND FUNERAL 23a. Part 1. Enter the disease, or complications, or heart failure. List only one tions that us of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each li Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discussion Injury Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cther (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 200 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Tes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSIS 10 Hospital: Other 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Ather (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number e of death (Item 23a) (Type, Print) NO CORNON FORMS ERNAZI

Registrar

State

31. Date filed (Month, Day, Year)

JUL 1 3 2004

ORIGINAL

couls

32. Registrar's Signature

			1 - State of	of Maryland / Department of Health and Certificate of Death	d Mental Hygier	ZUUU 22H35
	Physici /Medio	cal	Decedent's Name (First, Middle, Last) Pololo 4a. Facility Name (If not institution, give street and nu	Rosal (mber) 4b. City, Town, or Location of De	July 00	Day Year 3. Time of Death 6:10 PM
	Examir Funeral Director	ier	Johns Hopkins Boyview 5. Social Security Number 068-42-0962 1 M 2 F	Medical Center Baltimo 7. Age (In yrs. last birthday) 73 Yrs. Town, of Education of Be Baltimo Tourism of Education of Be Baltimo Tourism of Education of Be Baltimo Months Days Hours M	Irs. 8. Date of Birth	N/A
	ъ.	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore Co	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	al Director	8052 Gough Street	10f. Zip Code 21224		Citizen of What Country? USA
036	within 72 hours after death with the Maryland ane. than "naturat", or Itams 23e or 28e-f ehow ha Medical Evanthar nust be routified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 1 Yes 1 Yes	2 No Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "natural", or itams 23a or 28a-f show other than "natural", or itams Exercified at evant, the Medical Exercified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (N/A		working	Kind of Business/Industry
land	should be file nd Mental Hy markad oth matic evant	To Be (17. Father's Name <i>(First, Middle, Last)</i> Egnacio Rosal	18. Mother's N	Name (First, Middle, Maid Josefa Pa	
	nd 2 sh lith and 27 is rr r traum	-	19a. Informant's Name/Relationship (Type, Print) Dottie Rosal- Wife	19b. Mailing Address (Street and Number or 8052 Gough Street	Rural Route Number, Cit	y or Town, State, Zip Code)
Baltimore,	~ ~ .		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 7-1		Location - City or Town, State timore, MD
Baltin	permit. Page Department of Important: If any injury or ance.		21. Signature of Funeral Service thensee	22. Name and Address of Facility K a 1201 Dundalk Av	aczorowski	Funeral Home, PA
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on a Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not enter the mode of dying, such as card har. Hored thoracic worta (or as a consequence of):	985 _ 8	Approximate Interval Batween Onset and Death
8760,	cate be executed obly sician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):		
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of	Attending Physician: r death. actor: After this certific by the funeral director,	ation: To Be		Othor	Death (Check only one) J Home 5 Residence 28d. Describe how in	
Division	in Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home, farm, street, factory, office ing, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	(Check only 2 Medical Examiner: On the b	best of my knowledge, death occurred at the time, date and pla asis of examination and/or investigation, in my opinion, death oc ner stated.	curred at the time, date a	and place, and due to the cause(s)
	To the I within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 034/20	29d. [Date signed (Month, Day, Year)
	\		30. Name and address of person who completed causes Shane Koncad	se of death (Item 23a) (Type, Print) MO 4940 Factern Allow	NIP Pro 14	more MI) 21224
	Sta Registi	_	31. Date filed (Month, Day, Year) JUL 1 3 2004 32 F	29c. License number 29c. License number 034120 se of death (Item 23a) (Type, Print) MD 4940 Eastern Aver Registrar's Signature Apacle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.) 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 JULY 10, **Physician** 7:30 A M RELLSTAB HFI MA /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay, Year) MAY 10, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F NY 125-14-7046 86 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, its Madical Exemple; must be notified at 1 ☐ Yes 2 🕅 No PIKESVILLE Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 7 SUDBROOK LANE Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No À 3 ¥ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. SOCIAL WORKER HALLORAN GENERAL HOSP. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fi HOLZMAN SCHWARZ REGINA JULIUS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2107 RIDING CROP WAY - BALTIMORE, MD 21244 Pages 1 and 2 of Health a LORINE POWELL RAHMINGS/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB ANSHE VESHEAR 7/12/04 ROSEDALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheros derotic Neart **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) physicien Physician/Medical thet use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nhknown been sig Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 5 within 24 hours a To the Funeral C To the Hospital McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47683 Transmord Milli MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Mari Street Suite 200 Raymond Miller Reightstown 21136 31. Date filed (Month, Day, Year) 32, Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Maryland 21215-0036

Baltimore,

68760

Box

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 7:30 PM June 38 2004 Geneva Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinal Baltimore CILV Hospital .of If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 717-07-7524 Yrs. 90 Dec 15, **Director** Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f shov iral', or Itams 23a or 28e-f shov Exerciter out be natified at 1√ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4516 Garden Drive 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: black. 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic avant, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) licensed practical nurse health Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be unk unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health am 27 i Carrie Harrison/guardian 2126 Braddish Avenue Baltimore, MD permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State `4 □Donation 5 🕅 Other (Specify)in state 21. Signature of Funeral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 mans 23a. Pant. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Community disease or condition resulting in death) days acquired /Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner rsician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. | ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yroidism , page 2 autopsy performed? Yes 21 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Division of Vital Records.

certificate To the Hospital or Attanding Physician; within 24 hours after death, To the Funarel Director: A completely filled in by the fu

examiner?

27. Manner of Death 1 Natural

3 Suicide

29a. Certifier (Check only one)

4 Homicide

☐ Accident

1 ☐ Yes 2 🗙 No

5 Pending

Cmar

investigation

6 Could not be determined

		1	
ah je	Si	ai	ė
Reg	is	tra	ar

Certification: To

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner to be said of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 2004 28

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital 32. Registrar's Signature

31. Date filed (Month, Day, Year) JUL 1 3 2004

		•	For State Registrar	State of Ma	aryland /		artment rtificate			and M		giene	4 2	2038
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, L MChael 4a. Facility Name (If not institution, g Howard County	Schmid ive street and number)	+ ospital		4b. City, To	own, or		of Death	2. Date of Dea Month	Day 03 4c. Count	Year -	3. Time of Death 230 A M
	Funeral Director		5. Social Security Number 6. 069-32-6833		e (In yrs. last bi		If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt Jan 20	^h Yeard 42	9. Birthplac Country New	e (State or Foreign Ork
book of the Manager	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD How	ard	10c. City, Tov		umbia						10d.	Inside City Limits 1 ☐ Yes 2 ▼ No
đ đ	23a or 28	al Director	10e. Street and Number 5663 Brook Wa	y #2			10f. Zip C	Code	2104	44		10g. Citizen of	What Country USA	?
5-0036	72 Hours after beath with the maryral natural", or Itams 23a or 28a-1 show digal Evanit natel be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:			Was Deceder If Yes, specify 1 ☐ Yes 2	y Cubar	spanic Origin, Mexican Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		ce - American ack, White, etc fy: whi	·
121	than	Completed	15. Decedent's (Specify only highest g Etementary/Secondary (0-12)	Education trade completed) Coltege (1-4or the sunk)		(Give	dent's Usuat kind of work DO NOT use	done di	uring mos	t of work	ing		Business/Indus	
pu	ould be itted I Mental Hygi harked other hatic event, I	To Be C	17. Father's Name (First, Middle, La	st)			1	unk	18. Mothe	er's Name	(First, Middle,			unk
di i	l and 2 sri lealth and im 27 is rr har traum		19a. Informant's Name/Relationship Paul Rohner/fri 20a. Method of Disposition				ng Address (nd Numbe		A Route Numbe		, State, Zip Co	unk
Baltimore,	it. Fage rtment or rtant: If njury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	ensee state	cemete	ery, cre	matory or oth 2. Name and	er place						
Ba	Depa Impo any ir		23a. Aart1. Enter the disease, or co	Made, III	ector						1655 W.		A	reet pproximate terval Between
1760,		lical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence	of):	avdit	is					M	nset and Death
D. Box 68	at the date of the by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		⊒Ectopic preç ⊒ Other (spec						ate of delivery onth Da	ay Year
rds, P.O	signad d be de	þ	Part II. Other significant conditions Duckeren		out not resulting	in the t	underlying cau	use give	n in Part I			obacco use con res 2 \(\text{No} \)	atribute to the d	cause of death?
		Completed										rmed? 2 D No	prior to compl death?	y findings available letion of cause of ☐ No
of Vit	rnysician: in this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 @Inpati	ent 2 ER/C	utpatie			^{IC} 4□ Nu	ursing Ho	n <i>(Check only o</i> me 5 ☐ Resid	dence 6 □Ot		
_	ff fer	Certification:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could not determine	be 28e. Place of tn	iy Year)	Time of Intury	М		at ? ∕es 2□	No	28d. Describe h 28f. Location (S City or Tow	Street and Num		oute Number,
ā :	bspital or hours afte uneral Diri iy filled in I		4 Homicide 29a. Certifier 1 Certifying	Physician: To the best	of my knowledg	je, dea	th occurred at	t the tim	e, date an	nd place,	and due to the	cause(s) and m	anner as state	ed.
)	To the Hospital of Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Expension) 29b. Signature and titte of pertifier	and manner st										
			30. Name and address of person when CAPMEN SAL	o completed cause of	death (ttem 23a) (Type	Print)	1	ittle	Pa	toxent	PKW	1 Colo	umbia, MS
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1	32. Regist	rar's Signature		Sport	1				/		

				State of Marylan				•	~	ole.
			1 - For Stete Registrar	olalo ol malytan			of Death	-	Reg. No.2	11. 20000
	· ·		1. Decedent's Name (First, Middle, Las	t)				2. Date of De	eath	Year 3. Time of Death
	Physici /Medic Examir	cal	Clarence 4a. Facility Name (If not institution, give	R •			vart Jr.	JULY	Day - (O 4c. County	2004 12 PM
			Levindale Nurs:		_	Balti				
	Funeral Director		5. Social Security Number 6. Security Number 11 12 13 14 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months (n. (Month, Da	rth ay, Year))3 28	Birthplace (State or Foreign Country) MD
	yland 10w		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar	Director	MD NA	Bal	timor	e:				XXYes 2 □ No
	ith th	Dire	10e. Street and Number			10f. Zip Co	ode		10g. Citizen of W	/hat Country?
	s 23s	eral	4577 Derby Man		0 100		21215		U.S	
350	72 hours after death with the Maryland natural; or tlems 23a or 28a-f show Jical Evantral must be rollife of all	by Funeral	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	- 1		it of Hispanic Origin? Cuban, Mexican, Pue No <i>Specify:</i>	(Specify Yes or No erto Rican, etc.)	Specify:	o - American Indian, k, White, etc.
Maryland 21215-0036	72 hou	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual C	Occupation done during most of w	vorking	16b. Kind of Bu	
121	within ene. than "I	dmo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) 8vrs			ologist			of Medicine
0	be filed tal Hygi d other event, I	Be Co	17. Father's Name (First, Middle, Last)	0,125		- GCIII E		ame (First, Middle		
/lar		To B	Clarence Stewar	rt Sr.			Naomi	Brown		
lar)	2 sh and is m	1	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (S	treet and Number or i	Rural Route Numb	er, City or Town, S	State, Zip Code)
	1 an Heali em 2 ther		Rernice Stewart 20a. Method of Disposition	t-Wife 20b. Pl	4577 ace of Dispo	Derby sition (Name natory or othe	Manor D	rive, E		ce. Md 21215 Dity or Town, State
Ē	8 = 5		1 Burial 2 Cremation 3 □I 4 □Donation 5 □ Other (Specify				r place) . Park 7/	14/04		lstown, Md
	+ # # = -	H	21. Signature of Fineral Service Licens		22	. Name and A	Address of Facility		ranaz.	
ñ	Depar Impo		I mette &	- mes	Ma 43	irch E 300 Wa	T/H West bash Ave	. Balti	more. N	4d 21215
	าเงรเรเลก		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death ine cause on each line.	. Do not ent	er the mode o	f dying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a Due to (or as a consequ	ience of):	11.0	e 1/	1.7		ZIW
ĵ.		e	Sequentially list conditions if any, leading to immediate	b Due to (or as a consequ	ence of):	yea	M Ty	were		76 month
	be executed sician and burial-transit	Examln	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	End der	Chr	Mic	obskru	hive a	lisease	7.6 month
/60,	ite be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a donsequ	ence of):			_		
-	<u> </u>	dlcal		d						
ROX	n certif anding use a:	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date	of delivery
	I he law requires that the death certifica tite has been signed by the atlending ph bage 2 should be detached for use as th	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown		lEctopic pregr Other <i>(speci</i>			Mon	th Day Year
, s	res that igned by be deta		Part II. Other significent conditions co	ntributing to death but not resu	Iting in the ur	nderlying caus	e given in Part I.			bute to the cause of death?
Records,	w requir been s should	eted								Probably 4 Junknown
	10 17	e Completed						24a. Was autop perfo 1 Yes	osy pr rmede de	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
VItal	ding Physician: h. After this certific funeral director.	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E	R/Outpatien	t 3□ DOA	Other	eath (Check only of Home 5 Resid		(Specific)
	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending		28b. Time of Injury		Injury at Work?		now injury occurre	. , , , ,
	Attending r death. ector: After by the fune	catlo	2 ☐ Accident investigation		,,	М	1 ☐ Yes 2 ☐ No			
	al or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factory, of	ffice	28f. Location (S City or Tox		r or Rural Route Number,
:	To the Hospital of Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sicien: To the best of my knov iner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at t estigation, in	he time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
:	To the	Me	29b. Signature and title of certifier			29c. L	cense number		29d. Date signed	(Month, Day, Year)
	(Mulani	no -		1	F18 PP		Aulu-1	12004
	h		30. Name a d addre s of person who co	ompleted cause of death (Item	23a) (Type, I	Print)			VA	
	J		Augul TA	mani 21	134	万分	ehredes	e ane	1821	nMore -
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 3 2004	32. Registrar's Signati	Urey O	ports				

			1 - For State Registrar		f Marylar		artment rtificate			and M		Reg. No.	001	2201	
Г	Physic		1. Decedent's Name (First, Middle ARTHUR	SMIT	74						2. Date of De Month	Pay	Zear Zw4	3. Time of Dea	M.
	/Medi Examir		4a. Facility Name (If not institution				4b. City, To	own, or L	ocation o	f Death	UT	4c. Co	ounty of Deatl	11 /	1
	,		UNIVERSITY OF MY						MORE						
.4	Funeral Director		5. Social Security Number 223.60.1345	6. Sex 1√XM 2□ F	7. Age (In yrs. 60	(ast birthday) Yrs.	If Under 1 Months I	Days	Hours	Min.	8. Date of Bit (Month, Da MAY 28,	ay, Year)	9. Birth Con V I	nplece <i>(Stete or For</i> <i>untry)</i> RGINIA	reign
	Mr. In		Usual Residence of Decedent								1311 203				
	show	5	10a. State 10b. County			ty, Town or Lo	cation							10d. Inside City Lin	
	28a-1	rect	MD 10e. Street and Number		BAL	TIMORE	10f, Zip C	ode				10g. Citize	n of What Co	1 Tes 2 XX	
	h with	al Di	4807 BAYONNE ST.				2120						STATES	,	
	ems	iner	11. Marital Status	12. Was Dec	edent Ever in U	l.S. 13.			panic Orig	gin? (Sp	ecify Yes or No Rican, etc.)		Race - Amer Black, White		
36	72 hours after death with the Maryland natural; or items 23a or 28a-1 show deat Esantrar must be incitified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marr XX 3 ☐ Widowed 4 ☐ Divorced		2 □ No ve		1 □ Yes 202		Specify:	,			oecify:BLACI		
9	n 72 hours "natural", edical Exe	ted t	15, Deceden	t's Education	4105.	16a. Deced	dent's Usual (Occupati	ion			16b. Kind	of Business/I	ndustry	
215	within 7. ene. than "n	nple	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work DO NOT use	done du retired)	ring most	of work	ing			,	
121			12	(· · · · · · · · · · · · · · · · · · ·	HOU	SING SUF						TH CARE		
land	b d la d	To Be	17. Father's Name (First, Middle, LARA SMITH	Last)				'			<i>(First, Middle</i> T THOMPS		imame)		
Ž	d 2 sh th and 7 is m traum		19a. Informant's Name/Relations. JUNE M. SM1TH		WIFE						MD 212		own, State, Zi	p Code)	
o o	of H of H of H or oth		20a. Method of Disposition 1		State	Place of Dispo cemetery, crem	natory or othe	er place)	- 1		Date 5, 2004		tion - City or T		
Baltii	permit. Pag Department Importent: any injury o		21. Signatura Funeral Service	OLL		MAI	. Name and A	Address 10RTU	of Facility ARY SI	, JPPOR	T/FINK F	UNERAL	SDALE, I		
			KELLY ORTCOR 23a. Part I Enter the disease, or shock or heart failure. List	FINK complications that of	MO114	18 426	CRAIN	HWY :	SW CLE	N BH	RNIE MD	21061		Approximate	
	Physician	M	Immediate Sause (Final disease or condition	PA	RASOI	NAZ	AB							Interval Between Onset and Death	J
	/Medical Examiner		resulting in death)		(or as a conseq										
		e.	Sequentially list conditions,	b. Due to	IDOCAK		5								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C		,									
0,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last		(or as a conseq	uence of):				-					
	the the	dlca		d											
Вох 6	death certifics e attending ph id for use as ti	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ancy						234	. Date of deliv	ion.	
	0 0 2	Physiclan/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown		pirth 2 ☐ Feta lant at time of d own		Ectopic pregi Other (speci					230	Month	Day Year	
S, D	requires that the een signed by th hould be detache	by Ph	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying caus	se given	in Part I.		23e. Did to	obacco usa	contribute to	he cause of death?	Y
ord	w requir been si should I										10	Yes 2/2/N	lo 3⊡Pro	bably 4 Unkno	wn
	The lar ate has page 2	Completed								_				opsy findings availa empletion of cause of	
Vita	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hemitali	0.					of Death	(Check only o	one)		- miw-	
to	Phys raldi	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1/1		ER/Outpatien 28b. Time of		Other:	4 Nur		ne 5 Resid			(y)	
on	Attending Phy r death. ector: After thi by the funeral of	tlon	1 Natural 5 Pending 2 Accident investig	g (Moni	th, Day Yeer)	Injury	м	. Injury a Work? 1 ☐ Ye	u os 2∐N		EDG. Describe r	low injury of	scanea		
Jivis	or Attendi after death. Director: A in by the fu	ertification;	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	et, factory, o	ffice		1	28f. Location (S City or Tox	Street and N vn, State)	umber or Run	al Route Number,	
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: comptetely filled in by the	edical Co	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the Examiner: On the band man	best of my kno asis of examina ner stated.	wledge, death	occurred at t	the time, my opin	, date and	I place, a	and due to the	cause(s) and date and pla	d manner as s	stated. the cause(s)	
	To the i	Me	29b. Signature and title of certifier		TOT STATEGE.		29c. L	icense n	number			29d. Date si	gned (Month,	Day, Year)	
			Duntle	· S.7	1		F	717	162	4		7/	12/0	4	
	10		30. Name and address of person with the state of the stat	who completed caus			Print)				MD Z			,	
	Sta Registr		31. Date filed (Month, Day, Year)	, 32. R	egistrar's Signa		rocks	,							

Madaline Saunders
Baltimore, Maryland 21215-0036

	E
Vital Records, P.O. Box 68760,	Hospitel or Attending Physician: The law requires that the death certificate be executed
т.	dea
Ö	the
-	tha
Records	The law requires
ion of Vital	vsician:
0	P.
Division	Hospitel or Attending

		for 1_ State	Type or Print State of Man	yland / D	Indelible Ink. Department of H Certificate of I	ealth and M	lental Hygi	ene	ole.
		Registrar 1. Decedent's Name (First, Middle, La	st)		Certificate of I	Jean	2. Date of Death		3. Time of Death
Physici /Medic		MADELINE MARIE SAUN	DERS				July_	Day 3	Year 7:02 PM
Examin		4a. Facility Name (If not institution, give		\ \	4b. City, Town, or	Location of Death	.\	4c. County of	of Deeth
· · · · · · · · · · · · · · · · · · ·		5. Social Security Number 6.3	Sex 7. Age (III	n yrs. last birth	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
Funeral Director			□ M 2√xF		rs. Months Days	Hours Min.	AUG 10, 1	\$944)	MD MD
and w		Usuel Residence of Decedent 10a, State 10b, County	10	Dc. City, Town	or Location				10d. Inside City Limits
Maryi -f sho	tor	MD ANNE AR	UNDEL.	GLEN I	BURNIE				1 □ Yes 🎗 💭 No
ith the or 28s	Oirec	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland by diene by deed of ther than "natural", or fleme 23a or 28a-f show avent, the Medical Examiner must be notified at	Funeral Director	7735 B&A BLVD APT D	12. Was Decedent Eve	r in I t S	21060 13. Was Decedent of H	icognio Origina (Sp.		UNITED ST	FATES - American Indian,
ifter de	Fun	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	1 11 0.3.	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black	White, etc.
iral', o	d by	3 ☐ Widowed 4 反反ivorced	Year or Dates:		1 ☐ Yes 2 ☐ No XX	Specify:		Specify:	WHITE
n 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	turing most of work	ing 1	6b. Kind of Bus	iness/Industry
d withi giene.	omo:	Elementary/Secondary (0-12)	College (1-4or 5+)	НО	USE KEEPING			NURS INC	HOME
tal Hyg	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	aiden Sumame)
2 should be filled within and Mental Hygiene. Is marked other than sumatic avent, tra Me	^L	CARLYLE ERICH 19a. Informant's Name/Relationship	Type Print)	19h	Mailing Address (Street	EDNA	Al Route Number	City or Town 9	State Zin Codel
is a should be filed within 72 hours after death with the Maryla of Heath and Merial Hygiens the Maryla the Maryla at Heath and Merial Hygiens the Merical, or thema 23a or 28a-f show then traumatic avent, the Medical Evant set must be notified at		VANESSA EASTON	1,400, 7,440,	2,500,0	69 LEYMAR RD G			ony or rown, o	1416, <i>21p</i> 0000)
Dealthing E, My permit. Peges 1 and 2 Department of Health s Important: If Itam 27 is any injury or other tra		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐		20b. Place of I	Disposition (Name of , crematory or other place	, [Oc. Location - C	City or Town, State
L Peges tment of I tant: If It		*4 □Donation 5 □ Other (Speci	y)	OAK LA	WN CEMETERY		, 2004	BALTIMORE	MD
permit. Departments Imports any inju		21. Signature of Funeral Service Lice	10		22. Name and Addres	L HOME, P.A			
		23a. Part 1 Enter the disease, of conshock or heart failure). List on	plications that caused the	death. Do no	426 CRAIN H				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		umor					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of	():				
100 p.	er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	DPTC esneupeano	6 NEUCI	1)15ea	5 e		
cuted	Examiner	that initiated events	· Acter	000/6	rtic Card	ova colo	1)\50	36	
be executed icien and burial-transit	al Ex	resulting in death) Last	Due to (or as a co	onsequence of	f):				
	edica		d						
w requires that the death certificate been signed by the attending physishould be detached for use as the	Physician/Medic	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of p		3 □Ectopic pregnancy				of delivery
the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown		5 Other (specify)	<u> </u>		Mont	th Day Year
that the ed by detacl		Part II. Other significent conditions	contributing to death but n	ot resulting in	the underlying cause give	en in Part I,	23e. Did toba	icco use contril	bute to the cause of death?
quires n sign uld be	ed by						1 🗆 Yes	2 □ No 3	3 ☐ Probably 4 ∰Unknown
law requas been 2 should	Completed						24a. Was an autopsy	24b. W	ere autopsy findings available for to completion of cause of
ysician: The lav ysician: The lav is certificate has director, page 2 a	Сош						perform	ed? de	eath? ☐ Yes 2☐ No
v 1.c sician certifii rector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	2 C 5 D 10	nationt 3 DOA Othe	26. Place of Death			
g Phys er this	n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outp	me of 28c. Injury	4 🗀 Hursing Ho	me 5 Resider 28d. Describe how		
endin sath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	n	sa) III		res 2 □ No			
or Att or Att after d Direct in by	Certification:	3 Suicide 6 Could not be determined		- At home, fari Specify)	m, street, factory, office		28f. Location (Stre City or Town,		r or Rural Route Number,
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the	al Ce	29a. Certifier 1 Certifying Pi	nysician: To the best of m	ny knowledge,	death occurred at the tim	e, date and place, a	and due to the cau	ise(s) and man	ner as stated.
the Ho in 24 h the Fu pletely	edical	one)	niner: On the basis of exa and manner stated	amination and	or investigation, in my of	pinion, death occurr	ed at the time, dat	e and place, ar	id due to the cause(s)
To I To I	Σ	29b. Signature and the of certifier	0	100	29c. License	number	29	d. Date signed	(Month, Day, Year)
n/		30. Name and addreg of person who	completed cause of death	(ltem 23a) (7	Type Print)	4448	4	1-4	1-04
Q.		Chike	Lumo	71.5	0 611	To al	bodied	State	lateral la
Sta		31. Date filed (Month, Day Year)	32. Registrar's	Signature	Sports				
Registr	al	302 4 5 200-	1	1	Lines				

			1 - For State Registrar		Marylar		artment of			lental Hygie	201	04 22042
ı	Physic		Decedent's Name (First, Middle, Last MOLLY VIOLA SA	IGE						2. Date of Death Month	Day	Year Year 1 45 pm
	/Medi Examii		4a. Fecility Name (If not institution, give		9r)		4b. City, Towr	n, or Location	of Death		4c. County	
			CARROLL COUNTY GENERA	L HOSPITA	L		WES	TMINSTER	₹		CARR	O LL
	Funeral Director		223 30 0203	7. M 2/XXF	Age (In yrs. 92	last birthdey) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth Month Day, You 4/20/1912	ear)	Birthplace (State or Foreign Country) LEE CO., VIRGINIA
	e Maryland ia-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD CARROLL	COUNTY	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 XXNo
	h with th	ai Director	10e. Street and Number 3822 BACKWOODS ROAD				10f. Zip Code	21158		10g.	Citizen of V	Vhat Country?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "naturel", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ⚠ Midowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X Xio	l	Was Decedent of Yes, specify C			ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. : WHITE
Maryland 21215-0036	d within 72 h giene. ir than *natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		or 5+)	(Give life. L	lent's Usual Occ kind of work dor DO NOT use ret. HOMEMAKER	ne during mo: ired)	st of work	ing 16t	OWN	siness/Industry
yland	2 should be filed within and Mental Hygiene. Is marked other than surnatic event, I.a.M.	To Be C	17. Father's Name (First, Middle, Last) OSCAR TANKERSLEY					ı	DA FL	e (First, Middle, Mai E TCHER		
	and 2 shealth and n 27 is m		19a. Informant's Name/Relationship (Ty MOZETTA HAMMONS	oe, Print)						AP, VA 2427		State, Zip Code)
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 **Surial 2 □ Cremation 3** **4 □ Donation 5 □ Other (Specify)	emoval from Sta	te C	cemetery, cren	sition (Name of natory or other p	1				City or Town, State
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8760,	Physician /Medical Examiner physician and physician and physician in physician in physician are physician at the physician are physician are physician at the physician are	dical Examiner	Immediate Quise (Final disease or condition resulting in death) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	Due to (or a	as a conseq	uence of):) N's	Δ1.	SEI	AS E		YEARS
O. Box 6	ath certific ittending p or use as i	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 Yes 2 No 9 Unknown	3c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of d	Il death 3 🗌	Ectopic pregnar Other <i>(specify)</i>				23d. Date Mon	o of delivery th Day Year
rds, P.	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions con							23e. Did tobacc	_	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,		Completed	GASTEC							24a. Was an autopsy performed 1 Yes 2 D	? pr	fere autopsy findings available for to completion of cause of sath?
I Of VII	ding Physician: h. After this certifica funeral director, p	n: To Be	27. Manner of Death	ospital: 1 Ulnpa 28a. Dale of In (Month, L		ER/Outpatient	3 DOA C	other: 4 🗆 Nu	irsing Hor	(Check only one) ne 5 ☐ Residence 8d. Describe how in		
IVISIO	or Attendin ter death. irector: Aft by the fur	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of I		Injury ome, farm, stre		⊒Yes 2□	-	8f. Location (Street City or Town, St	end Number	r or Aural Aoute Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical Cer	29a. Certifier (Check only one) (Check only one)	ician: To the bes	st of my kno of examina	wledge death	occurred at the	time, date an	d place, a	nd due to the cause	(0) and	ner as stated. nd due to the cause(s)
	To the comple	Σ	29b. Signature and title of certifier		stated.		29c. Lice	nse number		29d. I	Date signed	(Month, Dey, Year)
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2.4	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture spo	res/	,		21157		

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Security Name (frost mathematics) year larged and name of the property of th				WILLIAM ALF	RED SO	UDERS		Т			8:45 A ^M
Secretal Security Number 10				4a. Facility Name (If not institution, give	street and number)		4b. City, Town,				
S. Social Source Supervisor State S. Social Social Supervisor State S. Social					PEAKE HOSPI	CE	LINTH	ICUM		ANNE ARUN	IDEL
The control of the co						- 14	day) If Under 1 Year Months Days	If Under 24 Hrs. 8	3. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
The Street and Number Too County Too C				104-20-0122		/6 ''	5.		03/12/19	Pen Pen	nsylvania
17. Father's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 19. International Summer of Rural Route Number of		yland sow				10c. City, Town	or Location				10d. Inside City Limits
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Physician // Idea Cancer of the lung Cancer of				23a. Part1. Enter the disease, or comp	lications that caused th	e death. Do not	enter the mode of dyi	ng, such as cardiac or r	espiratory arrest,	rei, Mary	Approximate
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the contribution of the cause of the		death e atte d for	icla	in the past 12 months?	4 Pregnant at tin			<i>f</i>			,
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25. Was case referred to medical examiner? 1	ď١	S 5.	nple							24b. Were auto	psy findings available mpletion of cause of
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? M 28c.	<u> </u>	cate	Co							f? death?	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? M 28c.		uician certifi rector	00	examiner?	Hospital:		Oth				
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D23743 July 6, 2004	<u> </u>	Atter	ifica	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm,			Location (Street	and Number or Rura	il Route Number,
D23743 July 6, 2004	5	rs afte	Cert	4 - Hornicide	building, etc. (Specity)			City or Town, St	tate)	
D23743 July 6, 2004		dospi t hour uner uner		29a. Certifier (Check only 2 Medical Exam	sician: To the best of n	ny knowledge, d	eath occurred at the tir	ne, date and place, and	due to the cause	e(s) and manner as si	ated.
D23743 July 6, 2004		tha hin 24 the F the F nplete	Nedi		and manner stated	f.			at the time, date :	and place, and due to	the cause(s)
		To To COL	-	290. Signature and title of certifier	11000	131				-	
		M				0		43	Jul	Ly 6, 2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, 7525 Greenway Ct. Dr., Greenbelt, Maryland 20770		101					·	+ Maruland	20770		
State 31. Date filed (Month, Day, Year) 32. R. pistrar's Signature		Stat	te	31. Date filed (Month, Day, Year)	32. Redistrar's		, ereemper	rialy LailQ	20//0		

			1 - For State Registrar				lealth and	Mental Hygie			
Ph	nysicia	an.	Decedent's Name (First, Middle, Las.					2. Date of Death Month	Day Year	3. Time of Death	
	Medic		Janet	Sharp				July 11	, 2004	7:50 P ^M	
E	xamin	er	4a. Facility Name (If not institution, give 903 Mastline I				or Location of Dea \mathtt{apolis}	ith	4c. County of Dea		
Fur	neral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday	/) If Under 1 Year	If Under 24 Hr.		Anne Arundel 9. Birthplace (Stete or Foreign Country)		
Dire	ector		145-30-5077 10 10 10 10 10 10 10 10 10 10 10 10 10	□M 21XF	Yrs.	Months Days	Hours Min	APR 9,	1937 I	llinois	
the Maryla 28a-f shov	offfied at	ector	Maryland Anne A		10c. City, Town or I	nnapolis				10d. Inside City Limits 1 ☐ Yes ②☐ No	
th with	ast be	al Dir	10e. Street and Number 903 Mastline Dri	ve		10f. Zip Code	21401	10g.	Citizen of What C USA	ountry?	
5-UU30 72 hours after death with the Maryland natural; or Itams 23a or 28a-f show	any injury or other traumatic event, the Middeal Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Dyes 2 No If yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🌠 No		Specify Yes or No- no Rican, etc.)	14. Race - Am Black, Whi		
A I A I D-UUSO d within 72 hours aft giene. er then "natural", or	e Medical S	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	ation during most of wo	orking	b. Kind of Business	,	
filled Hygie	nt, th		17. Father's Name (First, Middle, Last)	4	Teac	ner	18. Mother's Na	me (First, Middle, Maid		ool System	
Maryland od 2 should be file th and Mental Hy 77 is marked oth	lc eve	To Be	Otis Fromm Her	rmann				n Doris Al	•		
2 should and Men is marks	auma		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mai	ling Address (Street		ural Route Number, Ci		Zip Code)	
ore, IV as 1 and 2 of Health item 27 i	her tra		Robert E. Sharp/h	usband	903	Mastline	Drive A	nnapolis,	MD 21401		
Dallimore, Sermit. Pages 1 a Separtment of Hea mportant: If item	or ot		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ F	Removal from State		osition (Name of ematory or other place			. Location - City or	•	
permit. Pages Department of I	njury		 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service training 		_	ematory,	-			ore, MD	
Dall permit. Departr importa	any ir		Dawn F. McD	onato mula	()	Cremation 299 Frede	ssectety rick Roa	of Maryla d Baltimo	nd, Inc.	1 2 2 2	
15	9		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused to ne cause on each line	he death. Do not er	nter the mode of dyin	ig, such as cardia	c or respiratory arrest,	<u> </u>	Approximate Interval Between Onset and Death	
Physic /Med	lical		disease or condition resulting in death)		consequence of):	Cune	G h			8 mouth	
Exam			Sequentially list conditions.	b							
p	ısit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of).						
sxecut and	al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
ificate be ex g physician	the burial-transit	calE		d							
rtifical ng ph	asth		IF FEMALE:		-270	=======================================				•,	
it the death certificate be executed by the attending physician and	tached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year	
hat h	eq	٦	Part II. Other significant conditions co	ntributing to death but	not resulting in the t	underlying cause give	en in Part I.			o the cause of death?	
v requ	should	etec						1 Tes	2 NO 3 P	robably 4 Unknown	
ician: The law requires t	or, page 2	e Completed	or W.					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of	
	Ŧ .	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	lospital: 1 □ Innatient	2 ER/Outpatie	nt 3 DOA Othe		ath (Check only one) dome 5 Residence	2 COV (2		
	ori I	ü	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o	of 28c. Injury Work	at	28d. Describe how in		city)	
Attending r death. ector: After	the fu	catle	1 ▼Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be			M 1 🗆 '	Yes 2 □ No				
tal or Attending s after death.	d in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, st (Specify)	reet, factory, office		28f. Location (Street City or Town, Sta	and Number or Ru ate)	ural Route Number,	
To the Hospital or within 24 hours after To the Funeral Dire	oletely fille	Medical C	29a. Certifier 1 Certifying Physical Chack only 2 Medicel Exemi	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	th occurred at the timivestigation, in my op	e, date and place pinion, death occu	a, and due to the cause urred at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)	
To the within	com		29b. Signature and title of certifier	x1	11	29c. License			Date signed (Monti		
	X		Com X Var	SUN		024	1532	J	uly 12.	2004	
	1		30. Name and address of person who co	empleted cause of dea	th (Item 23a) (Type,	Print) outh Con	rene 5	treet But	(more)	uD 2128	
3	Stat gistra	9	31. Date filed (Month, Day, Year) JUL 1 3 2004	32. Registrar	s Signature	11					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of Imary		Certifica			violitai i iy	Reg. No. 2 0 (14 2	2045
	D!		1. Decedent's Name (First, Middle, Last,						2. Dete of De Month		Year 3. T	Time of Death
1.	Physici /Medi			seph Sh	ea				July	9 2	-007	1.73 am
1	Examir		4a Fecility Neme (If not institution, give Manor Care Rossvi				46	o. City, Town, or L				α-
			5. Social Security Number 6. Sec		yrs. lest birth	day) If Und	ler 1 Year	Rossvil If Under 24 Hrs.	8. Date of Birt	th	imore (
	Funeral Director			M 2□F 83		rs. Month	s Days	Hours Min.	(Month, Da Dec. 1	y, Yeer)	Country) Maryla	(State or Foreign and
	ylend		10a. Stete 10b. County	100	. City, Town	or Location				 		nside City Limits
	Ba-f s	Director		timore			Du	ndalk				☐ Yes 2 🔀 No
	ath with the Maryler 23s or 28s-f show Lat be notified at		10e. Street and Number			10f. Z	Zip Code	2122		10g. Citizen of W	/het Country? l States	~
	se 23u	era	7916 Lynch Road	12. Was Decedent Ever	in U.S.	13 Was Dec	edent of His				- American Inc	
Maryland 21215-0020	72 hours efter daath with the Marylend naturel', or fterne 23s or 28s-f show dical Examiner must be notified at	by Funeral	1 □ Never Married 2€XMarried 3 □ Widowed 4 □ Divorced	Armed Forces? 1X Yes 2 □ No	WII		ecify Cuban	penic Origin? (Sp., Mexican, Puerto Specify:	Rican, etc.)	Specify:	k, White, etc.	
2-0	"naturel",	eted	15. Decedent's Edu (Specify only highest grad		16a. [Decedent's Us 'Give kind of v	sual Occupat	tion uring most of work	king	16b. Kind of Bus	siness/Industry	
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	iio do not 1i11 Fc		· ·		Stoo	1 Indus	ctro
d 2	be filed withintal Hygiene. d other than event, tre M		12 Years 17. Father's Neme (First, Middle, Last)		I.	TIII FC		18. Mother's Nam	ne (First, Middle,	Maiden Surname		s C L y
an	ental	To Be	Michael Shea						Flynn		,	
ary	should be ind Mental i marked c umatic ev	F	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b.	Mailing Addre	ess (Street ar	nd Number or Ru	rel Route Numb	er, City or Town, S	State, Zip Code	9)
Ž.	and 2 salth a 27 is		Mrs. Kathleen A.					oad Dun	dalk, M	aryland	21222	
Baltimore,	of He of He fitam		20a. Method of Disposition ★○ **Burial 2 □ Cremation 3 □ F	Removal from State	Ob. Place of I cemetery	Disposition (No., crematory or	lame of r other place		Date	20c. Location - 0		
Ē	. Peg mant mant: i	1	4 Donation 5 Other (Specify)	Н	olly F	∏ill M∈	m Gdn	s. 7/12	/2004	Middle	River,	, Marylan
Bal	permit. Peges 1 and Dapartmant of Health important: If itam 27 any injury or other ti ence.		21. Signature of Funeral Service Licens	au l	0					f Dundal Marylan	•	
			23a. Pan1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	death. Do no	ot enter the m	ode of dying	, such as cardiac	or respiretory a	rrest,	Inten	roximate val Between
The second	Physician		Immediate Course /Final								Onse	et and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a	14604	onsequence o					DA	75
		ē		CKP 5	to (or es a co	onsequence o	f):	Acc			t i	
/_	uted Id ansit	in.	Sequentially list conditions	Due	to for as a co	onsequation U	D.	ACC	1 Den I			
3	tificeta be exaduted ig physician end es the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			FIB		TION			İ	
68760,	eta b hysic the bi	dica	that initiated events resulting in death) Last	v		nsequence of					1	
9 X	0	₩.	L.	d								
Вох	as thet tha death certificeta be ignad by the attending physicia be detached for use es the bur	Physician/M							005 Did			and deaths
P.O.	tha d by the ached	hysi	Pert II. Other significant conditions cor				cause giver	n in Part I.		tobacco use con Yes 2 No		
	s thet ynad t	by P	COPONALY	ARIGUY	1136	BE						
of Vital Records,	equir een s buord	Completed							24a. Was perfo	an eutopsy rmed?	available	ion of cause
æ	Physician: The law r r this certificate has b aral director, page 2 sh	шо							101	res 2 No		2 □ No
ta	lan: 1 rtifica ctor, p	Be C	25. Wes cese referred to medical examiner?					26. Place of Dea	th (Check only o	ne)		
>	Physician: this certific ral director,	일	1 Yes 2 No	lospital: 1 Inpatient	2 ER/Outp			4 ter Nursing m		dence 6 □Othe		
	5 5 5		27. Manner of Death 1 ■ Maturel 5 ■ Pending 2 ■ Accident investigetion	28a. Date of Injury (Month, Dey Yea	28b. Ti	me of iury M	28c. Injury Work? 1 🗆 Y	at ? es 2□No	28d. Describe I	now injury occurre	bd	
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director After this completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.		n, street, facto	ory, office		28f. Location (S City or Tox	Street and Numbe vn, Stete)	er or Rural Rou	te Number,
	ne Hospi n 24 hou ne Funer sletely fill	edicai		ner: On the best of my ner: On the basis of exar and manner steted.								cause(s)
	Vithis To th comp	M	29b. Signature end title of certifier				9c. License			29d. Date signed	Ma	
	ti		Done	~3		L	553	06		JULY 9	200)4
	101		30. Neme and eddress of person who co	Que K	* *	-	Rn	C112.323		NO 2		
			DENNIS IF SDIE 1 31. Det inb (Minth Day Xear)	9106 / 1 2 32. Registrar's S		SUMA		- 11/6-205	DATE	2	123/	
	Sta	-	JOE T 9 5004	Denerga	19	Mary	11					

DHMH 16 Ray 6/95

			- FOI	artment of Health and Me	ental Hygiene Reg. No. () ()	22046
	Physici		1. Decedent's Name (First, Middle, Last) Catherine	Cwangon	2. Date of Death Month Day Year July 9, 2004	3. Time of Death 10:00 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 13 Centre Avenue	4b. City, Town, or Location of Death Dundalk		more Co.
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 M F 75 Yrs.	Months Days Hours Min.		irthplace (State or Foreign Country) Iaryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		Dundalk	10d. Inside City Limits 1 ☐ Yes 2€©No
	with the	Direc	10e. Street and Number 13 Centre Ave.	10f. Zip Code 21222	10g. Citizen of What C	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event. I've Medical Evantical must be notified at once.	by Funeral Director		Was Decedent of Hispanic Origin? (Specify tess, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☒ No Specify:		nerican Indian,
21215-0036	d within 72 ho giene. rr than "natur Ire Medicul	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) DOMEMAKEY	16b. Kind of Busines Own	•
Maryland	uld be file Jental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) William Huber	18. Mother's Name (i	First, Middle, Maiden Surmame) Emily Cushing	
Mary	ind 2 sho alth and A 27 is ma or trauma			ing Address (Street and Number or Rural F 04 Harview Ave. Ba	Route Number, City or Town, State, ltimore, Marylan	
Baltimore,	Pages 1 a lent of He nt: If item ry or othe			osition (Name of particular of or other place) ill Mem. Gdns. 7/12,		
Balti	permit. Departm Importa any inju		100 h 8 10 1	2. Name and Address of Facility Duda-Ruck Funeral Ro 7922 Wise Ave. Dund	ome of Dundalk,	Inc. 21222
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ter the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between Onset and Death
8760	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last c			
.O. Box 6	ath certif ittending or use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of d Month	elivery Day Year
rds, P	quires that the de in signed by the a uld be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
Il Records,		Completed by			autopsy prior to performed death?	autopsy findings available completion of cause of s 2 \square
f Vital	> .5 D	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (control 3 DOA Other: 4 Nursing Home		ecify)
ion of	Attending Ph r death. ector: After th by the funeral	ation: T	27. Manner of Death Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 29b. Time (Month, Day Year)	of 28c. Injury at 28 Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)	d. Describe how injury occurred	
Division	in Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28	f. Location (Street and Number or F City or Town, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the cause(s) and manner a l at the time, date and place, and du	as stated. ue to the cause(s)
	To th withir comp	Me	29b. Signature and title of certifier HAF Shunde my	29c. License number 2 6434	29d. Date signed (Mor	1
	Y		30. Name and address of person who completed cause of death (Item 23a) (Type ARTHUR SCHROFDER M) Johns Hopk	ins a winte Warsh	4924 Comphell Blue	I white Merch Me
	Sta Registr		31. Date filed (Man) Day Yar) 2004 32. Registrar's Signature	Sparks!		

in the past 12 months?

9 Unknown

Live birth 2 Fetal death 4☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

3 ☐ Probably 4 ☐ Unknown

3. Time of Death

0703 A. M

1 Yes 2 No

Approximate Interval Between Onset and Death

Year

2□No 1 Yes 26. Place of Death (Check only one)

Yes 2 No

25. Was case referred to medical examiner 1 XYes 2 □ No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation

1 Inpatient 2X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 8-04

28b. Time of Injury C: YOUM

28c. Injury at Work? 1 ☐ Yes 2 💢 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred bject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Staje) Mi Ltm building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Till Certifying Prhysician: To the dest of my knowledge, seam occurred at the time, date and place, and date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

OCME

July 9, 2004

Name and address of person who completed cause of death (Item 23a) (Type, Patricia Aronica-Pollak, M.D.

6 Could not be determined

111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

P.O.

Division of Vital Records,

Hospitel or Attending Physicien:

death.

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this

After t

Director:

24 hours a

the

2

Aq

Completed

Certification:

Medical

		1 = For State Registra AMEND ITEM #	State of Mar					giene 1eg. No? () () (,	2.201.8
Physici /Medic		Decedent's Name (First, Middle, Last Deloris	DOLORES C	. SMITH	Smith		2. Date of Dea Month 7	Day Year 7 2004	3. Time of Death 7:10a
Examin		4a. Facility Name (If not institution, give Levindale N. H.			4b. City, Town, or Balt:	Location of Death imore If Under 24 Hrs.		4c. County of Deal	
Funeral Director		5. Social Security Number 6. Se 219–28–5330 Usual Residence of Decedent	X 2X F 7. Age (/	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 2-25-	r, Year) Co	thplace (State or Forei buntry) Md.
72 hours after death with the Maryland neturel; or Items 23e or 28e-f show Jisal Exame wr must be invittled at	Director	10a. State 10b. County Md. NA	11	oc. City, Town or Lo	imore				10d. Inside City Limi 1 X Yes 2 □ N
th with th		10e. Street and Number 5201 Barbara Ave			10f. Zip Code 21206			10g. Citizen of What Co USA	ountry?
urs after des el', or Items	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 Me No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Whit	
within ene. then "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11th grade		(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of work	ing	16b. Kind of Business. Pub City of Ba	lic School
	To Be C	17. Father's Name (First, Middle, Last) Barrett	G.	Franklin		18. Mother's Name	e (First, Middle,	Maiden Sumame) Johnso	m
0.000	-	19a. Informant's Name/Relationship (T) Angela Smith		19b. Mailir		nd Number or Run		r, City or Town, State,	
0 0		20a. Method of Disposition 1 \(\forall \)Burial 2 \(\subseteq \) Cremation 3 \(\supseteq \) 4 \(\subseteq \) Donation 5 \(\supseteq \) Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cres	sition (Name of matory or other place	9)	Date	20c. Location - City or	Town, State
permit. Pag Department Importent: f eny injury o		21. Signature of Euneral Service Licens		22	Forest Ve Name and Address March F.	s of Facility	B-04 Bal 1101	Owings Mi timore, Md E. North	. 21202
nysician /Medical Examiner		23a. Part1. Enter the disease, or compositions, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	cations that caused to ne cause on each line. Cardio Due to (or as a c	thrombol	er the mode of dying	g, such as cardiac	or respiratory and	rest,	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	Due to (or as a c						
e attending	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the common of the com	Fetal death 3	Ectopic pregnancy Other (specify)		VYCHAROVE TA	23d. Date of del Month	livery Day Year
signed d be de	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	nderlying cause give	n in Part I.		obacco use contribute to es 2 □ No 3 □	o the cause of death?
	Completed						24a. Was a autop perfor 1 Tyes	sy prior to death?	utopsy findings availa completion of cause of
r death. ector: After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner Death 1 Matural 5 Pending investigation	Hospital: 1 patient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time of Injury	28c. Injury Work	at	me 5 Resid	ne) lence 6 Other (Spe ow injury occurred	cify)
9	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or Run, State)	ural Route Number,
within 24 hours after	edicai C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the cred at the time, c	cause(s) and manner as date and place, and due	s stated. s to the cause(s)
within Toth comp.	Me	29b. Signature and title of certifier Makingapahse N	1·D-		29c. License	number 74 65	2	29d. Date signed (Mont	h, Day, Year)
8		30. Name and address of person who con N.S. Rajapakse, H.D.		h (Item 23a) (Type, ain Street)	Print) Suite 200,	Reiste	rstown,	MD 21130	0
Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Sporks				

			For State Registrar		iarylanu /		tificate of	Death		Reg. No.	-00	22019
	Physici		1. Decedent's Name (First, Middle,						2. Date of D Month	Day		3. Time of Death
	/Medic Examir		Harry Joseph 4a. Facility Name (If not institution, g		r)		4b. City. Town, o	r Location of Death	July	8	2004 County of Death	9:35 a ^M
	Examir	er	Stella Maris		,		Timo			1	Baltimor	
	Funeral				ge (In yrs. last i	birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, O			place (State or Foreign ntry)
1.	Director		212-46-1923	1√2 M 2□ F	58	Yrs.			Nov.	23 19	945 N	1Ď
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	the Maryland r 28e-f show notified at	ğ	MD Baltin	2010	Tim	oniu						1 ☐ Yes 2 X No
	or 28e	irec	10e. Street and Number	101 6	1 1111	orna	10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	23e c	alD	2418 Chetwood	Circle_Ap	t. 101		210	93		U	ISA	
	tems	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. W	as Decedent of H Yes, specify Cubi	lispanic Origin? (Span, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ameri Black, White,	
5-0036	ours after de ral', or items Examinar re	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Ves 2 If Yes, Give Year or Dates	1 No : 163-167	1	☐ Yes 2 🙀 No	Specify:			Specify: Wh	ite
15-0	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23e or 28e-f show imatic avant. If a Madical Examinar must be notified al	Completed	15. Decedent's (Specify only highest	grade completed)		Sa. Decede (Give k life. D	ent's Usual Occup and of work done O NOT use retired	eation during most of world)	king	16b. Ki	ind of Business/Ir	dustry
2121	filed with Hygiene. thar thai	omo	Elementary/Secondary (0-12)	College (1-4or	75+)		Inspec				General	Motors
b	al Hyg	Be C	17. Father's Name (First, Middle, La	,				18. Mother's Nan	ne (First, Middle			
ylaı	Ments Ments arked	Tof	John A. Sawye	er					Theres			
Maryland	es 1 and 2 should be fi of Health and Mental F Fitam 27 is marked ot r other traumatic avar	3	19a. Informant's Name/Relationship					and Number or Ru d Circle				
	1 and Health 8m 27 ther t		Jill W. Sawyer 20a. Method of Disposition	/wife					Date	200.10	ocation - City or To	21093
altimore,	ages nt of in t: If its		1 Burial 2 Cremation 3 '4 Donation 5 Other (Spe		•		ition (Name of atory or other plac	1//12	2/04			owii, diate
Ŧ	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice		Baiti	22	Name and Addre	Cremator ss of Facility	•		rel, MD	
ñ	Dep land		Michael J.	lagie		L.	emmon F	uneral H	ome of	Du	laney Va	illey, Inc. nia Rd.
ΙΙ.	14,		23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that cause	ed the death. Do	o not ente	r the mode of dyir	g, such as cardiac	or respiratory a	arrest,	v. rado	Approximate Interval Between
	Pnysician :	i n	Immediate Cause (Final disease or condition		AGE REN	AL D	I SEASE					Onset and Death
	/Medical Examiner		resulting in death)		s a consequenc							
		10	Sequentially list conditions, if any, leading to immediate cause Enler Industrying	b. Due to (or a	s a consequenc	e of):				_		
	uted d ansit	Examiner	Cause (Disease or injury									
Ď,	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or a	s a consequenc	e of):						
68760,	icate be physicia s the bu	Medical		d						-15		
99	artifica ing ph e as t	Med	IF FEMALE:									
Вох	faw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transif	Physiclan/A	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pregnancy	,		2	23d. Date of delive Month	ery Day Year
o.	at the de by the a stached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time of death	2 🗆	Other (specify) _					
٥	that in the post of the post o	by Ph	Part II. Other significant condition	contributing to death	but not resulting	g in the und	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
rds	quires nn sign uld be								1 🗀	Yes 2[□No 3□Prot	pably 4 TUnknown
ecords,	aw requas been 2 should	Completed							24a. Was	an	24b. Were auto	psy findings available
Œ	The ate he	mo:							auto perfe	ormed? 2 7 No		mpletion of cause of 2 No
Vital	ician: T certificat rector, pi	Bec	25. Was case referred to medical examiner?					26. Place of Dea			and a street of the	
of V	Physician: r this certifica ral director, i	2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpat			3□ DOA Oth	4 Nursing H			Other (Specif	HOSPICE
on C	ling After une	lon	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year) 28b	. Time of Injury	28c. Injur Wor M 1 □	yat k? Yes 2 □No	28d. Describe	how injur	y occurred	
Division	tand death tor: the	ficat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 28e. Place of Ir	niury - At home.	farm, stre	et, factory, office	165 2 140	28f. Location /	Street and	d Number or Rura	I Route Number
Ω	F 6 F C	Certification:	4 Homicide determine	building, e	atc. (Specify)				City or To	wn, State,)	
	Hospits 4 hours Funarel tely fille	Medical C	29a. Certifier 1X Certifying (Check only 2 Medical Ex	Physician: To the bes aminer: On the basis	t of my knowled of examination a	lge, death and/or inve	occurred at the tirestigation, in my o	ne, date and place, pinion, death occur	and due to the	cause(s) date and	and manner as s	tated.
	To tha within 2 To the complet	Mec	one) 29b. Signature and title of certifier	and manner s	itateu.		29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
	F ≩ F 8			/~			DI	4777	e-	7	18/11	/
	INX /		30. Name and address of person wh	o completed cause of	death (Item 23a	a) (Type, P	Print)	1312	7	1	10/04	
	M.		DR. TARIO MAHMO		ULANEY			TIMONIUM,	MD 210	193		
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	4	Spork					
	Registr	ar	.111 137	004	merca,	10	Jan Jan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Please	State of Ma	aryland / De	epar		lealth and	All Copies Mental Hy		e noi	22050
	Physici /Medic		1. Decedent's Nam	e (First, Middle, La e M. Scot						2. Date of De Month	Bath Da	y 2004	3. Time of Death
	Examir				e street and number) cement Cen	ter	1	4b. City, Town, o	or Location of De den Cho			County of Dear	
	Funeral Director		5. Social Security N 419-48-9	116	Sex 7. Ag	e (In yrs. last birthe 9 Yr	//	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bi in. 1 - 3 - 1	rth 915 ^{ear)}	9. Bird Te	thplace (State or Foreign ountry) Kas
	ryland how		Usual Residence o 10a. State	10b. County		10c. City, Town							10d. Inside City Limits
	the Ma	Funeral Director	MD 10e. Street and Nu	Baltimon	re	Catons	svi]	lle 10f. Zip Code	-		10g. Cit	izen of What Co	1 ☐ Yes 2/Q/No ountry?
	ath with a 23a of neat be	ral Di		len Choice	·			21228				USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other treumatic event, the Medical Exartment by myllied at ance.	by Fune	11. Marital Status 1 ☐ Never Marr 3 🏋 Widowed	ried 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		If Y	as Decedent of H Yes, specify Cubi ☐ Yes 2000 No	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify.Whi	e, etc.
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212	ygiene. ygiene. her thar	Completed by	Elementary/Seco		College (1-4or !	0+)		cher	,				1 Teacher
land	ild be fil lental H ked oth Ic even	To Be		(First, Middle, Last es Millic						_{lame (First, Middle} Florence			
Maryland 21215-0036	ind 2 shou alth and M 27 is mar ar treumat	-		ame/Relationship (S Scott -				Address (Street 1 Thicke		Rural Route Numb Columbi			Zip Code)
Baltimore,	Pages 1 ament of He ant: If item ury or othe		1 4 □ Donation 2	Cremation 3 5 Other (Special		Balto.,	oisposit crama Was	tion (Name of Itory or other place Sh. Cren	matory	Date 7/6/04		ure1,MD	Town, State
Balt Balt	permit. Depart Import any inj		1///2	uneral Service Lice	C. Xa	sell	958		ston Scison Ave	hwab Fun Baltim		HS ^m 212	
68760,	Physician /Medical Examiner physician and physician physician with physician	llcal Examiner	23a. Part 1. Efter to shock, or hea Immediate Cause disease or condilloresulting in death) Sequentially list cor if any, leading to ir cause. Enter Undicause (Disease or that initiated event resulting in death)	on trial ure. List only (Final on on on on on one one	Due to (or as	ne.): S			iac or respiratory a			Approximate interval Between Onset and Death
.O. Box	that the death certificate bed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	! months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal death		ictopic pregnancy Other (specify)	y 			23d. Date of dei Month	ivery Day Year
۵.	sign sign d be	by	Part II. Other signi	ficant conditions	contributing to death b	ut not resulting in t	he und	erlying cause giv	en in Part I.		tobacco u Yes 2		the cause of death?
al Records,		Completed								24a. Was auto perfo 1 Yes		prior to death?	topsy findings available completion of cause of 2 No
f Vital	% ≤ p	To Be	25. Was case reference examiner?	/	Hospital: 1 ☐ Inpatie	ent 2□ER/Outp	atient	3□ DOA Oth	or	eath (Check only) Home 5 Resi		6 □Other (Spe	cify)
Division of	ling After	Certification: 1	27. Manner of Deal	5 Pending investigatio		iry 28b. Tin y Year) Inji		28c. Injur Wor M 1	yat rk? Yes 2 □ No	28d. Describe	how injur	y occurred	
Divi	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide 4 Homicide	6 Could not be determined	building, et	ury - At home, farn c. <i>(Specify)</i>				City or To	wn, State)	iral Route Number,
	he Hosp in 24 hou he Funei pietely fil	edical	29a. Certifier (Check only one)	1☑ Certifying Pt 2☐ Medical Exa	nysician: To the best miner: On the basis o and manner st	f examination and/	death o or inve	occurred at the tir stigation, in my o	me, date and pla opinion, death oc	ice, and due to the courred at the time,	date and	and manner as place, and due	stated. to the cause(s)
	or or party	N	29b. Signature and		. Alm	fm.	ρ.	29c. Licens	447)	18	29d. Dat	te signed (Monti	t, 2004
	\		11	ress of person who	completed cause of c			_{int)} l Maider	n Choice	Lane B	altin	nore, MI	21228
***	Sta Registi		31. Date filed (Mor	1 3 2004	32. Registr	ar's Signature	de	sarksi					

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Maryland		rtment of F			211115	22051
	° Physicia	an	Registrar 1. Decedent's Name (First, Middle, Last			inouto or	Death	2. Date of Death Month	Day Year	3. Time of Death
1	/Medic Examin	al	4a. Facility Name (If not institution, give	Sandlass street and number)		4b. City, Town, o	r Location of Death	June	23 200 4c. County of De	4 9:25AM
	Examin	ei	University of	Manyland Media	dCen	4	0 11.	1019		
	Funeral		5. Social Security Number 6. Se 219-26-5664	x 7. Age (In yrs. last ☐ M 2점 F 66	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) (rthplace (State or Foreign Country)
	Director		Usual Residence of Decedent					Nov 26,1	93/ Mai	cyland
	show	2	10a. State 10b. County	10c. City, To						10d. Inside City Limits 1 ☐ Yes 2√ No
	the M	Directo	Maryland Anne Ar	undel Ann	apoli	S 10f. Zip Code		10	g. Citizen of What 0	
	th with	al Di	909 Yardarm Lane			2140	1		U.S	•
	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V		lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
36	irs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 27 No If Yes, Give Year or Dates:	1	□Yes 24ŪkNo	Specify:		Specify:	White
21215-0036	4 within 72 hours after death with the Maryland jiene. r then "neturel", or liems 23e or 28e-f show the Medical Examan of must be codified at		15. Decedent's Edi (Specify only highest grad		6a. Deced	ent's Usual Occup	ation during most of worki	20	6b. Kind of Busines	s/Industry
121	within ane. Ihen "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	Assistan		DDG 7 1	
9	other i	a)	17. Father's Name (First, Middle, Last)	A	dillill	strative	18. Mother's Name		PPG Indus aiden Sumame)	tries
ylan	2 should be and Mental Is marked of reumetic even	To B	Anthony J. Tarnt	ino, Sr.			Helen A.	Far1ey		
Maryland	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 Is marked othe or other treumetic event,		19a. Informant's Name/Relationship (T				and Number or Rura			STERIO COS
	is 1 and 2 of Health item 27 other tre		Louis H. Sandlass 20a. Method of Disposition	20b. Place	e of Dispos	ition (Name of	Lane Ann		Maryland Oc. Location - City o	
E O	Pages nent of I int: If it		1 Burial 2 Cremation 3 □1 1 Donation 5 □ Other (Specify,	removal from State	•	atory or other plac Cemetery	6-28-	2004 в	altimore.	Maryland
Baltimore,	permit. Pages Department of Importent: If i eny injury or once.		21. Signatur F Feral Servic icens		22	Name and Addre	ss of Facility			Inc. land 21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. If ne cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	intracere br	al	home	orchage			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):		1			J
		ner	if any, leading to immediate	Due to (or as a consequent	ce of):					
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
8760,	ate be executed hysician and the burial-transit	calE	resulting in deathly East	Due to (or as a consequent	ce or):					
9	ate the	ledic		d					1/	
Вох	death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy	,		23d. Date of de	elivery Day Year
0.	0 40 5	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	1 5□	Other (specify)			World	Day Toal
<u>α</u>	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the un	derlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ords	w require been sig should b							1 ☐ Yes	2 No 3 □ F	robably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of s 2 No
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		3☐ DOA Oth	26. Place of Death			
of		\vdash	1 Yes 2 No 27. Manner of Death	1	Outpatient b. Time of Injury	3 DOA 28c. Injur	y at 2	ne 5 ∐ Residen 8d. Describe how	ce 6 □Other (Speninjury occurred	ecify)
sion	Attending r death. sctor: Afte	catlo	1 Natural 5 Pending 2 Accident investigation	(INOTAL, Day Teal)	Hijury		Yes 2 □ No			
Division	iel or Attenos s after deatl el Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,		lural Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau and at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	-> .		29c. Licens	e number		I. Date signed (Mon	
ľ	1		1/2/	MD)-\ (T	716	20		8-23	,-04
	10		30. Name and address of person who o	ompleted cause of death (Item 23	ou H	o Gre	ene st	Balton	8-23	21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		had			7.10	
		1	JUI 1 3 2004	Dejeva y	1	medi				

			1 - For State Registrar	State of Maryla			of Health and of Death	Mental Hy	giene	22052
	Dhyoisi	,	1. Decedent's Name (First, Middle, Last)				2. Date of De	eath Day Yea	3. Time of Death
	Physici /Medi		ALICE V. SIGMAN					July	6 2004	
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, To	own, or Location of De	ath	4c. County of Di	eath
	·		Genesis Eldercare		(6 (Seve:	rna Park Year If Under 24 Hi		Anne A	
8	Funeral Director		5. Social Security Number 6. Se. 317-12-5204	M 211 86	rs. last birthday) Yrs.		Days Hours Mi	n. (Month, D		Birthplace (State or Foreigr Country)
			Usual Residence of Decedent					Apr 6,	1918	IN
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	d within 72 hours after death with the Maryland Jiene. I than "natural", or Hems 23a or 28a-f show The Medical Exactive froughe modified at	Funeral Director	MD Anne Aru	ndel M	lillersv	ille				1 ☐ Yes ZV No
	or 28	lre	10e. Street and Number			10f. Zip C	ode		10g. Citizen of What	Country?
	23a	rai	327 Lazywood Cou	rt		21	108		USA	
	r dez	nei	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Deceder If Yes, specify	nt of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	0- 14. Race - Ar Black, W	merican Indian, hite, etc.
ð	or H	by Fu	1 Never Married 2 Married	1 ☐ Yes 27 No If Yes, Give		1 ☐ Yes 2 ☐		,		White
Ş	ural	q p	3 ₩ Widowed 4 Divorced	Year or Dates:						
ς Υ	n 72	lete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual (kind of work DO NOT use	Decupation done during most of w retired)	orking	16b. Kind of Busines	ss/Industry
21215-0036	withi ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemal			Own Home	a
0	rould be filed within 1 Mental Hygiene. narked other than natic event, the M		17. Father's Name (First, Middle, Last)	2-				ame (First, Middle	o, Maiden Sumame)	
a	d be ental ked c	To Be	Edward Neuman				Mab	el DeLo	nα	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the Ma	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (S			er, City or Town, State	a, Zip Code)
Σ	rt 2		Patricia Scanlon	/ Daughter					ille, MD 2	
Baitimore,	Health item 27 other tra		20a. Method of Disposition	201	D. Place of Dispo	sition (Name	of	Date	20c. Location - City	
Ē	0 0		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		D Veter	-	netery Ju	1y 9 2004	Cwron ord 1	11.
	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens						Crwonsvil	
ñ	permit. Departr Importa any inje		1	MOUZE				Clan R	n Funeral H urnie, MD 2	Home PA
7	* · · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ications that caused the de						Approximate Interval Between
i.	Medical Examiner Assistant and purial-transit	cal Examiner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):					
P.O. DOX 001	death certifica e attending pt id for use as tl	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions con	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 1 Unknown	etal death 3[of death 5[□Ectopic preg □ Other (speci	ify)	220 Did	23d. Date of c Month	delivery Day Year
ras,	w requires t been signe should be	ed by	- Tarris official state of the		assuming in the o		se given iir r ait i.		Yes 2 No 3	
	The lay ate has page 2	Completed							psy prior to ormed? death	autopsy findings available o completion of cause of ? as 2 \(\text{No}\)
NIG.	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check only o		
5	Phys this al dii	P.	1 ☐ Yes 2 ☑ No	1 ∐ Inpatient 2		-	7	-	dence 6 Other (Sp	pecify)
	of fig.	lo	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o Injury		. Injury at Work?	28d. Describe	how injury occurred	
DIVISION	Attender death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	M reet, factory, o	1 ☐ Yes 2 ☐ No	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospitat or within 24 hours after To the Funeral Dire completely filled in b	Medical Co	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kiner: On the basis of exame and manner stated.	knowledge, deat ination and/or in	h occurred at vestigation, in	the time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	ompl	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Date signed (Mo	nth, Day, Year)
	- s + ō /		> monego	m			D575	31		
	h		30. Name and address of person who co	ompleted cause of death (f	tem 23a) (Tune	Print)	0 0 . 0		July DE	7.0-0.7
			mobil Nessi				millers.	nue, s	n) 2/100	P
9	Sta Registi		31. Date filed (Month, Oay, Year)	32. Registrar's Sig	gnature &	100	als			

			Please	State of Maryland / De			
			1 - State	_	ertificate of Death	Reg.	and the second s
			Registrar 1. Decedent's Name (First, Middle, Las		Ortinoato or Dodin	2. Date of Death	3. Time of Death
ı	Physici			Ellen J. Sv	veigart	Month	Day 2004 0646 AM
	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De	ath	4c. County of Deeth
			Union Hospital		Elkton		Cecil
	Funeral		Social Security Number 6. Security Number	TH SETE	Months Days Hours M	n. (Month, Day, Ye	9. Birthplece (State or Foreign Country)
	Director		170-28-7605 Usuel Residence of Decedent	69 Yrs		06/29/19	35 Pennsylvania
	ow a		10a. State 10b. County	10c. City, Town o	Location		10d. Inside City Limits
	Mary Ff 8h	tor	PA Lancast	er East Co	ocalico Township ([Denver)	1. ✓ Yes 2 □ No
	or 28;	Director	10e. Street and Number		10f. Zip Code		Citizen of What Country?
	72 hours after death with the Maryland "natural", or Itams 23s or 28s-f show calcal Exponiter cast be multiled at		259 North Reams	stown Road	17517		USA
	tams	Funeral	11. Marital Status	Amed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pure	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by F	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Specify:		Specify: White
21215-0036	thou stural	edt	15. Decedent's Ed	ucation 16a De	cedent's Usual Occupation	166	. Kind of Business/Industry
215	C	piet	(Specify only highest gra- Elementary/Secondary (0-12)	de completed) (G	ive kind of work done during most of w e. DO NOT use retired)	rorking	
21	T 70 2	Completed	8	0	Inspector	- I	Hat Manufacturing
ם	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	den Sumame)
yla	should be ind Mental imarked	ပ	Walter S			dia Palm	
Maryland	2 0 = 0		19a. Informant's Name/Relationship (7		ailing Address (Street and Number or		
	s 1 and of Health item 27 other tr	1	Clayton L. Sw 20a. Method of Disposition		N. Reamstown Resposition (Name of	The state of the s	Location - City or Town, State
Baltimore,	Pages nent of I int: If it	13	1 Burial 2 □ Cremation 3 3 \(\) 1 □ Other (Specify	Hellioval IIolii State	sposition (Name of crematory or other place)	(2 (222) E	ast Cocalico Twp.
ij	그 든 본 중 .		21. Signature of Funeral Service Licen	Muddy	20.11		Denver, PA 17517
ä	Depa Depa Impo sny ir	6 6	Michel & Gla	Kelle- #M00696	Diehl Funeral Hom	7 S. Main S	t., Mt. Wolf, PA 1734
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused the death. Do not			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	w/ 1 1	T C . 1	4	Onset and Death
	/Medical		resulting in death)	Due to as a consequence of):	dustance the		minutes
О	Examiner		Sequentially list conditions,	b			
	ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury	Due to (or as a consequence of):			
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence of):			
760,	te be executed ysician and ie burial-transit	cai		d			
9	leath certificate I attending physi I for use as the L	edi		·		7740	
Вох	death certifical e attending phy id for use as th	N/us	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death	3 Ectopic pregnancy		23d. Date of delivery
. B	0 0 0	by Physician/Medi	in the past 12 months? 1 Yes 2 No		5 Other (specify)		Month Day Year
P.0.	requires that the leen signed by th hould be detache	Phy	9 Unknown			oo. Diday	
Ś	w requires that s been signed t should be deta	by	,	entributing to death but not resulting in the	e underlying cause given in Paπ i.		co use contribute to the cause of death?
0.00		etec	Diabetes in	ellitos		1 🗆 Yes	
3ec	The law ite has b bage 2 sl	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a						1 Yes 2 %	
Vital Record	hysician: The law his certificate has b I director, page 2 s	o Be	25. Was case referred to medical examiner? 1 RYes 2 No	Hospital: 1 [] Innation 2 [FR/Outer	Other	eath (Check only one)	- 50
of	a Phy er this	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☑ ER/Outpat	of 28c. Injury at	Home 5 ☐ Residence 28d. Describe how in	
ion	Attending Physician: or death. ector: After this certific by the funeral director,	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No		
Division of	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
	ital or A			3, (-,)/		2.17 5. 10411, 51	,
	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edicai	(Check only 2 Medical Exam	rsician: To the best of my knowledge, de iner: On the basis of examination and/or	eath occurred at the time, date and plan investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2 the I mplet	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	T To		21/2 MA =	min min	D005330	230.	1 2 rd 2 AA/1
	10		30. Name and address of person who	completed cause of death (Item 23a) (Typ		1 30	143, 2009
	W		m. 00 . 11		nion Hospital	Elle Lana	mD 31931
	Sta	te	31. Date filed (Month, Day, Year)	32. Begistrar's Signature		CIRTURE	1110
	Registr	ar	uu 1 3 200	A. Denewar	Systems		

			For State Registrar	State of I	Maryland / Dep Ce	artment ertificate				-	giene Reg. No	3 (3)	4	220)54	
	Dharaini		1. Decedent's Name (First, Middle, Last)							2. Date of De Month	aath Da	v Y	ear	3. Time	of Death	
	Physici /Medio		Margaret Doris Ste	ward						July 1	1, 2	004		3:45	P "	Λ
)	Examir		4a. Facility Name (If not institution, give	street and number	er)	4b. City, 1	Town, or	Location of	of Death		4c.	. County of	Death			
			Casey House			W Hada		Rockv				ontgor				
п	Funeral		5. Social Security Number 6. Sex	M 212 F	Age (In yrs, last birthda) 82 Yrs.	/) If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Yea <i>r)</i>			lace (State	or Foreig	ın
	Director		213-38-0625 Usual Residence of Decedent		02 110.					Nov 13	, 19	21 3	scot	land		
	land ow		10a. State 10b. County		10c. City, Town or	ocation							1	Od. Inside (City Limits	s
	Mary 1sh	ţō	MD Montgome	rv	Damascus									1 🗌 Ye	s 2 N	0
	7 28a	Director	10e. Street and Number	- 1	- Damas o a B	10f. Zip	Code				10g. Cit	izen of Wh	at Coun	itry?		
	h with		25901-D Ridge Mano	r Dr.		2087	72				Gre	at Br	ita	in		
	deat deat	Funerai		12. Was Decede	ent Ever in U.S. 13	. Was Deced	ent of Hi	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race -				
9	after or ite		1 Never Married 2 Married	1 Tes 2	T3.No	1 ☐ Yes 2		Specify:	i, Fueito i	nican, etc.)		Black, Specify:	vvriite,	etc.		
21215-0036	d within 72 hours after death with the Maryland jiene. r than "naturel", or Items 23a or 28a-f show The Medical Exaction must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	s:	1 - 703 2		ороспу.					nite	<u> </u>		
5-(natu	Completed	15. Decedent's Edu (Specify only highest grade		(Giv	edent's Usua e kind of wor	k done d	durina mosi	t of workir	ng		ind of Busir	ness/Ind	dustry		
12	within iene. than "	d u	Elementary/Secondary (0-12)	College (1-4	or 5+)	<i>DO NOT us</i> maker	e retired	'/			Own	Home				
7	filed v Hygie other i		17. Father's Name (First, Middle, Last)	2	Home	maker		18. Mothe	r's Name	(First, Middle	Maiden	Sumame)				
and	eve d) Be	John R. Adams					Annie		verend	,	0007				
7	should be and Ments marked umatic e	្ន	19a. Informant's Name/Relationship (Ty	oe. Print)	19b. Mai	ling Address	(Street a			I Route Numb	er City o	r Town Sta	ate Zin	Code)		
Maryland	and 2 sho ealth and n 27 is mu		Victoria Markus/Da	•						, Gaith)	
ē,	- F 5 5		20a. Method of Disposition		20b. Place of Disp					ate		cation - Ci				
JU OF	bages ent of ht: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ P * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	Chesape					ul 13 004	Belt	csvili	le.	MD		
altimore,	permit, Pages Department of I Importent: If ite any injury or of	Ιi	21. Signature of Funeral Service License	2 9		22. Name and	d Addres	s of Facilit	У							
m	Depar Depar Impol		> Stale A Lole	mann		Rapp I			Cre:	mation ver Spi	Serv	vices . MD				
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caus	sed the death. Do not e	nter the mode	of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be		
	Pnysician		Immediate Cause (Final disease or condition		i- Stage CO	חכ								Onset and	Death	
	/Medical		resulting in death)		as a consequence of):	. D										_
в	Examiner		Sequentially list conditions,).												
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):											
	and I-tran	хап	that initiated events resulting in death) Last		as a consequence of):								=			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be delached for use as the burial-transit	aiE			,											
687	licate liphysis the t	dic														
Box (eath certific attending pl for use as t	/W	IF FEMALE: 23b. Was decedent pregnant		me of pregnancy							23d. Date o	f delive	irv		
ă	death atte	cial	in the past 12 months?			□Ectopic pre □ Other (spe						Month		Day	Year	
0	that the de led by the a detached t	Physician/Medicai	9 Dunknown	9□ Unknow	n											
ď.	es tha igned be det	ру Р	Part II. Other significant conditions con			underlying ca	use give	en in Part I.		23e. Did t	obacco u	ıse contribu	ite to th	ne cause of	death?	
Records,	w require been sig should b	ed		Disease	<u> </u>					1 🔯	Yes 2	□ No 3{	Prob	ably 4 🗌]Unknowr	1
BCC C	law re as be 2 sho	plet	Essential Hypert	ension						24a. Was		24b. Wei	e autor	psy findings	s available	e
m m		Completed								perfo 1 ☐ Yes	rmed?	dea	th?	2 □ No		
Vital	Physician: Th rthis certificate ral director, paq	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	one)_					
of \	Physic this or	၉	1 ☐ Yes 2 ☒ No		atient 2 ER/Outpati			4 🗀 Nu		ne 5 🗆 Resi			Specify	/) Hos	spice	5
	ng ffe ne	inoi.	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year) 28b. Time Injury		3c. Injury Work			28d. Describe	how injur	y occurred				
isi	teat for: the	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of	Injuga - At home form	M troot factors		Yes 2 ☐ f		28f. Location (Stroot an	d Number	or Dura	I Pouto Nu	mbor	
Division	el or Attendii s after death. el Director: A ed in by the fu	Certification;	4 Homicide determined	building,	Injury - At home, farm, s , etc. (Specily)	deet, factory,	Office		-	City or To			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	710010710	111001,	- 1
	e Hospitel 24 hours a e Funerel letely filled		29a. Certifier 1 Certifying Phys	sician: To the be	est of my knowledge, dea	ith occurred a	at the tim	ne, date an	d place, a	ind due to the	cause(s)	and mann	er as st	ated.		
	To the Hospitel or All within 24 hours after or To the Funerel Directompletely filled in by	edical	(Check only 2 Medical Examination)	ner: On the basi and manner	s of examination and/or	nvestigation,	in my of	oinion, deat	th occurre	ed at the time,	date and	l place, and	due to	the cause((s)	
	To the within 2 To the complet	M	29b. Signature and fill of centiver					number	,		29d. Dat	e signed (A	Aonth, I	Day, Year)		
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	10		30. Name and address of person who co	•		, Print)			854			/	1			
	ι		Charles Harr		6001 Mun		4	ITTT R	coad,	Rockv	ттте	, MD				
	Sta Registi		31. Date file Month D3. 2004	1	istrar's Signature	spork										

DHMH 17 Rev 1/2001

St. A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year STEPHEN M. 2004 JULY 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death birthday | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 13, 19 CARROL CARROLL COUNTY GENERAL 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 215-58-2500 Usual Residence of Decedent 1**X**) M 2□ F 52 Maryland 1951 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4206 Hillcrest Ave. 21074 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ∑ Yes 2 □ No If Tes, Give Year or Dates: 1977-78 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) 4 years Automotive Repair Proprietor 18. Mother's Name (First, Middle, Maiden Surname) Katherine Mitchell

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examinating Instituted at Funeral 1 Never Married 2 Married altimore, Maryland 21215-0020 ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be William Herman Storck, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Galetree Ct. Cockeysville, Maryland 21030 a of Disposition (Name of Date 20c. Location - City or Town, State Suzanne S. Moran (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7-12-04 Baltimo<u>re, Maryland</u> 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner clanosis, and STAGE Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): as

≥X ER/Outpatient 3□ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

for use signed by the a d be deteched for

Physician

/Medical

Examiner

Directo

Funeral

Director

After this certificate has

Physician/Medical Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 27. Manner of Luath

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director,

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Mark D. Henser, MD

29c. License number

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2XNo

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

Street Greene Norte

32. Registrar's Signature

5 Pending investigation

6 Could not be determined

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

TOWNSEND, GROIDIE

	State of Maryland / Department of Health 1- State Registrar Certificate of Death		0.0.0.1
	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	Rag. No. 1 2 5 7
Physician	JULIA B. TIGER	Month	Day Year 254 P M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		4c. County of Death
		enie	ANNE ARUNDEZ
Funeral Director	5. Social Security Number 214-54-8085 6. Sex 1	Min. 8. Date of Bit (Month, Date of May 8,	ay, Year) Country)
	Usual Residence of Decedent	PIAT 0,	1910 INCLAND
show	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🏋 🛪 o
the Mi 289-f.: putility	MD BALTIMORE LANSDOWNE 10e. Street and Number 10f. Zip Code		
ifer death with the Mar ufter death with the Mar if he must be notified funeral Director	2400 TIONESTA ROAD 21227		10g. Citizen of What Country?
death ms 2 from 2	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No	
036 036 aurs after death with the Maryle Extra or Items 23a or 28e-f sho Exert in tens 23a or 28e-f sho Exert in tens 23a or 28e-f sho Exert in tens 23a or 28e-f sho	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify		Black, White, etc. Specify: WHITE
(1215-0036 within 72 hours after death with the Maryland ene. than "natural, or Itams 23a or 28e-f show the Mudral Exert her must be notified at empleted by Funeral Director	Year or Dates:		16b. Kind of Business/Industry
ind 21215-00 be filed within 72 hours at Hygisene. It hygisene. It hygisene. It have a dother than "natura avant, the Madical Be Completed	(Specify only highest grade completed) (Give kind of work done during modified DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	st of working	Tob. Kind of Business/filldustry
0 7 5 5	12 HOMEMAKER		OWN HOME
	17. Father's Name (First, Middle, Last) 18. Moth	er's Name (First, Middle	, Maiden Sumame)
larylan	PETER BOGART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb	ILIE (UNK)	City of Tour Clate Tie Code
re, Marylare, nad 2 should f Health and Meryla marke other traumatic	EMILIE BATEMAN 1 CHAIN O HILLS ROAD.		
re, M	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or Town, Slate
altimor mit. Pages partment of the portant: If the y injury or of	1 XXBurial 2 Cremation 3 XXRemoval from State 14 Donation 5 Other (Specify) ARLINGTON NATIONAL CEM.	7/22/2004	ARLINGTON, VA
Baltime permit. Pag Department Important: I any injury o gence.	21. Signatur Funeral Service CERT #M01148 22. Name and Address of Facil		RAL HOME, PA
	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock or heart failure. List enty one cause on each line.		
Pnysician	Immediate Cause (Final disease or condition netastatic pancreatic		Onset and Death
/Medical Examiner	resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
D, executed an and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
68760, ficate be executed from the purish and is the burial-transit edical Examir	resulting in death) Last Due to (or as a consequence of):		
68760, ificate be ex g physician as the burial edical E	d		
X 66 A Ging p ding p as a st	IF FEMALE:		
cords, P.O. Box (wrequires that the death certification signed by the attending should be detached for use a letted by Physiclan/Meters.)	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
.O. the day the ached	1 Yes 2 No 9 Unknown		
S, P S, P es that es that be determented by Pl	Part II. Other significant conditions contributing to death but not resulting in the dilutinging cause given in Part	I. 23e. Did t	obacco use contribute to the cause of death?
ords	hypertension	11	Yes 2 0 3 Probably 4 Unknown
al Record The law requir cate has been s page 2 should Completed		24a. Was	psy prior to completion of cause of
al Recate he cate he page		perfo 1 ☐ Yes	ormed? death? 2 No 1 Yes 2 No
f Vital F ysicien: Th is certificate director, pag	examiner?	e of Death (Check only o	
of N g Physi er this c eral dire	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Specify) how injury occurred
Sion or tanding Pheath. tor: After the tuneral cation; 7	2 Accident Investigation M 1 Yes 2	No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit Medical Certification; To Be Completed by Physiclan/Medical Examir	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
Epital ours a sural C	29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date an	nd place, and due to the	cause(s) and manner as stated
thin 24 hour thin 24 hour thin 24 hour thin 24 hour thin plately till	(Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, decone)	ath occurred at the time,	date and place, and due to the cause(s)
To the within To the comp		110	29d. Date signed (Month, Day, Year)
· 8)		July 6, 2004
		en Burne	MD 21061
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 3 2004 Server & Society		

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Н	Physic	ian	1. Decedent's Name (First, Middle Ruth Eva Tr							2. Date of I Month July	Death Day	Year 2004	3. Time of Death 9:35 AM
No.	/Medi Exami		4a. Facility Name (If not institution		nber)			4b	. City, Tow	n, or Location of De		ty of Death	9.55 AFI
	LXaiiii	1101	Long View N	lursing Ho	ome				Manc	hester		arrol	1.
	Funeral Director		5. Social Security Number 215–42–9083	6. Sex 1 □ M 2 1 F	- ' -	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8. Date of E	Sirth Day, Year) 1913	9. Birthp Coun	lace (State or Foreigr try) ●
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits
	n the Marylan r 28a-f show	φ	MD. Car	roll		Hampsi	tead					ľ	1 □ Yes 2 No
	or 288	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of	What Coun	try?
	23a c	ai	18609 Falls				2	1074			USA		
020	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural" be notified at he Mcdfeal Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For ed 1 \(\text{Yes}\) Giv Year or De	dent Ever in l ces? 2 No e stes:	J,S. 13. V	Vas Deced Yes, spec		panic Origi Mexican, Specify:	in? (Specify Yes or I Puerto Rican, etc.)	Bia	ice - Americ ack, White, ify: Whi	etc.
baitimore, maryland 21215-UU20	permit. Pages 1 and 2 should be filed within 72 hours after dea Inopartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items any injury or other traumatic event, the Widgel Examine mance.	Completed	15. Decedent (Specify only highes: Elementary/Secondary (0-12)	s Education t grade completed) College (1	4or 5+)	16a. Deced (Give life. L		al Occupat rk done du se retired)		of working	16b. Kind of I	Business/Inc	-
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lan,	2 sho and I is ma		19a. Informant's Name/Relationsh			19b. Mailin	g Address	(Street ar		or Rural Route Num		, State, Zip	Code)
e,	1 end lealth im 27 ther tr		Granville T.	Troyer	20h	186	09 Fa	alls	Road		ad, Md.		
٥	ages nt of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from S	late	Place of Dispos cemetery, crem				Date	20c. Location		
	nit. Pa antme artant artant injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Du	laney V	Name and			July 1	, 2004 Timon	ium, 1	/ld •
ğ	permi Depar impo any ir		23a. Payl 1. Enter the disease, or of shock, or freat failure. List of	levelt			Eckl 3296	hardt 5 Cha	Fune rmil	eral Chape Drive, Ma	l, PA	r. Md.	21102
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	that the death certif ed by the attending detached for use a	Physician/N	Part II. Other significant condition	s contributing to dea	ith but not res	ulting in the un	derlying ca	ause given	in Part I.		_	-	the cause of death? ably 4 🗌 Unknown
necords,	e law requires that has been signed t ge 2 should be dett	Completed by					_			24a. Wa	s an autopsy ormed?	avai	re autopsy findings lable prior to ipletion of cause eath?
										1 🗆	Yes 2☐No	10	Yes 2 No
ט אומו	sician: The certificete irector, pag	9 Be	25. Was case referred to medical examiner?	Hospital:				Other		f Death (Check only			
5	Attending Physician: r death. ector: After this certific by the funeral director.	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of		A Bc. Injury a Work?		ing Home 5 ☐ Res 28d. Describe	idence 6 ∐Oth how injury occur		
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5	5 # # E	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 200. Flace	of Injury - At h	ome, farm, stre	et, factory,	office	-	28f. Location City or To	(Street and Numb wn, State)	per or Rural	Route Number,
:	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one)	Physician: To the base	is of examina	wiedge, death tion and/or inve	occurred a estigation,	t the time, in my opin	date and p	place, and due to the occurred at the time	cause(s) and madate and place,	anner as sta and due to t	ted. he cause(s)
1	vithin 2 Vithe Comple	Me	29b. Signature and title of certifie				29c.	License n	umber		29d. Date signe	d (Month, D	ay, Year)
				V				03	3316	5	71.	3 (04	
	5		30. Name and address of person w	ho completed cause	of death (Iten	11(11)	rint)	Ph	_ }	(aut s	es & in	2 21	074
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture				9			

DHMH 16 Rav 6/95

			1 - For State Registrar	State of N	/laryland / D	epartme C <i>ertifica</i>			and N	_	giene Reg. Nø.	nnu	22059
			Decedent's Name (First, Middle, L.)	.ast)						2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Irwin P. T	rail						Ju1v	Day 7	Year 2004	12:50 P.
	Examin		4a. Facility Name (If not institution, g	ive street and number	or)	4b. Ci	y, Town, o	Location of	of Death		4c. (County of Death	
			Charlestown Ret	irement Ca	re Center			nsvil			I	Baltimo:	re
	Funeral				Age (In yrs. last birth	day) If Und		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h		place (State or Foreign intry)
	Director		217-14-9857	ILEM 2LIF	98 ^Y	s.				02/14/			MD
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location							10d. Inside City Limits
	faryli sho	ō					_						1 ☐ Yes 2 ⊠No
	the A	ect	MD Balt 10e, Street and Number	imore	Cat	onsvi	le ip Code				10g Citiz	en of What Cou	Intra/2
	with with	2				101.		11000			rog. Oniz		antiy:
	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show fra Madical Examiner must be notified at	Funeral Director	717 Edmondson A	12. Was Deceder	nt Ever in U.S.	13. Was De		21228 Ispanic Ori	gin? (Sp	ecify Yes or No-	- 1	USA 4. Race - Ameri	ican Indian,
(0	ritar	F	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2∑	s2				, Puerto	ecify Yes or No- Rican, etc.)		Black, White	, etc.
93	urs a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates	`	1 🗆 Yes	2X No	Specify:			3	Specify:	White
9	72 ho	Completed	15. Decedent's (Specify only highest of		16a. C	ecedent's U Give kind of	sual Occup	ation	t of work	ina	16b. Kin	d of Business/Ir	
2	thin .	ρie	Elementary/Secondary (0-12)	College (1-40		ife. DO NOT	use retired	d)	O WOIN	n ig			
7	ed wi	5	12	4		Senio	Vice					Banking	3
n	d oth	Be	17. Father's Name (First, Middle, La.	st)				18. Mothe	r's Nam	e (First, Middle,	Maiden S	Surname)	
yla	Men Men arka etic	ပ္	John Emory Trai							Thrift			· · · · · · · · · · · · · · · · · · ·
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship		19b. I	Mailing Addre	ss (Street	and Numbe	r or Run	al Route Numbe	r, City or	Town, State, Zi	p Code)
6	and lealth m 27 har t		Betty Neubauer/	Daughter		28 Ki	1941	on RI		Date -			
altimore,	ges 1 1 of 1- 1 ita or ot	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Star	20b. Place of E cemetery,	crematory o	other plac	e)		Date	20c. Loc	ation - City or T	own, State
<u>E</u>	Pa tmen tant:		'4 □Donation 5 □ Other (Spec	•	Druid	Ridge	Cemet	ery (07/2	6/04	Pike	sville,	MD
Ba	permit. Pages 1 and 2 should be tited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28e-f show any injury or othar traumetic event, the Modical Examiner must be notified at ance.		21. Signature of Funeral Service Lic	ensee		Sterl:	and Addres	ss of Facilit Shton	Sch	wab Fune	eral	Home, 1	Inc.
	40 = # O		fetter s.	telas		/36 Ec	lmonds	son Av	ле.	Baltimo	ore,	MD 2122	28
			23a. Part î. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	line.	t enter the m	ode of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
۲	Physician		Immediate Cause (Final disease or condition resulting in death)	_a DQ	nenti								Years
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):							•
		-	Sequentially list conditions,	b. Due to /or :	as a consequence of								
	ted 1sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due 10 (01 t	as a consequence of	·-							
	icate be executed physician and the burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):							-
8760,	siciar buri	dicai E											
687	ficate physics the	edic		d.									
ŏ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy	_					23	3d. Date of deliv	erv
$\mathbf{\alpha}$	d for	cia	in the past 12 months?	4☐ Pregnant	2 ☐ Fetal death at time of death	3 ☐Ectopic 5 ☐ Other						Month	Day Year
o.	that the de ed by the a detached t	hys	9 Unknown	9□ Unknown									
ر. م	es that igned b	by P	Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute to t	he cause of death?
ğ	w require been sig should b	pe t	Dusphara							1 □ Y	es 2 🗆	No 3□ Prol	bably 4 Unknown
Records,	aw re s bee	olet	010							24a. Was a		24b. Were auto	opsy findings available
	The tay te has age 2	Completed							_	autop perfor	med2	prior to co death? 1 ☐ Yes	empletion of cause of
ta		Be C	25. Was case referred to medical	1				26. Place	of Deat	1 ☐ Yes n (Check only or	2 No	1 165	<i>3</i> 2 140
<u> </u>		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 ER/Outp	atient 3	Oth	25		me 5 ☐ Resid		□Other (Specia	fy)
0	ig Physical this neral di		27. Manner of Death	28a. Date of Ir (Month, L	njury 28b. Tir	ne of	28c. Injun Worl			28d. Describe h			
ō	ttanding F death. tor: After the funera	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	on	,	M		Yes 2 □ I	No				
Division of Vital	after death Diractor: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Place UI	njury - At home, fam etc. (Specify)	, street, fact	ory, office			28f. Location (S City or Tow	treet and n. State)	Number or Run	al Route Number,
	talors aft al Di	Cer											
	tospi t hou unar	cai	29a. Certifier 1 Certifying I	hysician: To the beaminer: On the basis	st of my knowledge, of examination and/	death occurre	d at the tin	ne, date an	d place,	and due to the c	ause(s) a	nd manner as s	tated.
	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	Medicai	one)	and manner	stated.								
	with To	-	29b. Signature and title of certifier				9c. License			1 2	esa. Date	signed (Month,	Day, rear)
	11		monico	/	ノ		030	JARG	7		JUL	100	4005
	A		30. Name and address of person wh	o completed cause of	f death (Item 23a) (T	ype, Print)		_		r Cod	<	1	N
			Myla M Carp	UST W	1 III C	bid	00	DIO	eL	n Cot	BUCE	VILLE	MD
	Sta Registr		31. Dae filed (Month, Day, Year)	Some Sales	strar's Signature	for "	,						

				Please Type of Philit in Black indelible link. Ensure Al			
				1- State of Maryland / Department of Health and N Certificate of Death		2001	22060
					Reg. I	16-00	3. Time of Death
		Physici	an	1. Decedent's Name (First, Middle, Last)	Month E	Day Year	3: ISTIM
		/Medi		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deeth	3,1311.
		Examir	ner	Coton Wanor Backman	0	A//	4
		Euparal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth Month, Day, Yea	9. _{/Bilth}	place (State or Foreign
		Funeral Director		216-16-6660 12M 20F 77 Yrs. Months Days Hours Min.	July 15	1926 NIC	aruland
		P		Usuel Residence of Decedent	7		101 insite Challing
		arylar show	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
		8a-f	cto	Naryland NA Baltimore	1.0	0:::	
		with the Maryland a or 28a-1 ehow be notified at	Director	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Cou	ntry?
		irs after death with the Maryland if, or Items 23a or 28a-f ehow amin'an mual be notitied at	Funeral	170 FUDIAL GIVESI. ACCIO	acity Yes or No-	14. Race - Ameri	ican Indian.
M		Item Iner	'n	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
d	336	urs al	þ	3 Nowed 4 □ Divorced If Yes, Give 1 □ Yes 2 12 No Specify:		Specify: 8	ack
\leq	21215-0036	within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work.		Kind of Business/Ir	ndustry
7	218	thin 7	ple	Elementary/Secondary (0-12) College (1-4or 5+)	9	1_	: (1
13	21	fited with Hygiene other the	S	8 0 Iruch Driver		omme	ercial
-	nd	be fit d of	Be	T	e (First, Middle, Maid	on Sumame)	- 0
)	3	d 2 should be filed within th and Mental Hygiene. 7 Is marked other than traumatic event, I'le M	2	19a. Informant's Name/Relationship (Type, Print) (2, 25%) 19b. Mailing Address (Street and Number or Rura	(Paula Alumbas Cit	COLIE) [
2	Maryland	d 2 st th and 7 Is r traur		19a. Informant's Name/Relationship (Type, Print) (nece) 19b. Mailing Address (Street and Number or Rura	ALIO D	y or Town, State, 24	12 21211
7		1 an Heall tem 2	10		Pate 20c.	Location - City or T	own, State
0	ē	ages ont of t: If if		1 Surial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	2004 P	vita	MA
andy	Baltimore,	permit Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.	1	21. Signatore of Funeral Service dicensee () 22. Name and Address of Facility	_	ACT 10: 1	T.C.
~	Ä	Ded drive and page of the page		barend L. Kush 255 Physicity	tuner	of Heme	201016
1	to -			23a. Par1. Inter the disk se, or complications that cause the death. Do not enter the mode of dying, such as cardiac of shoot, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between
		Physician			dure		Onset and Death
		/Medical		resulting in death) Due to (or as a consequence of):			
		Examiner		Sequentially list conditions b. Renal Tai Lure			
		P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
		and trans	Cam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	760,	te be executed ysicien and e burial-transit	al E	South (of the distribution of).			
	387	physicate physical ph		d			
	Box 68	eath certific attending pl for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of deliv	ery
	B	atter of for c	clar	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
	P.O.	t the de by the tached	hys	9 Unknown			
3.1		res that igned to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	o use contribute to t	he cause of death?
KX	ğ	w require been sig should b	ed		1 🗆 Yes	2 No 3 Prot	bably 4 QUnknown
	900	as be	plet		24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
	E.	The law	Completed		performed	? death?	
	ita	sicien: Th certificate rector, pag	Be	examiner?	(Check only one)		
	× ×	Physicie this cert al direct	ဥ	1 ☐ Yes 2 K No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 12 Nursing Ho	me 5 🗆 Residence		fy)
	n C	ng f fter fter	ion:	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe how in	jury occurred	
	isio	death. death. ctor: A	cat	2 Accident investigation 3 Suicide 6 Could not be determined by the could not be determined b	28f. Location (Street	and Number or Rus	al Route Number
	Division of Vital Records,	after Direct	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, Sta		2. 770010 11001,
		Hospital 24 hours a Funerel I tely filled	aC	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	(s) and manner as s	stated.
		n 24 l	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time, date a	ind place, and due to	o the cause(s)
		To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and the of certifier	6(/- 1	Date signed (Month,	Day, Year)
		10		P West Attunking 1/1/steven 1233	042 J	wy 10	2004
		9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X/A/DHAU 550 400 ROWAN BLVCL 30	3 Bult	TMDO	2/239
		Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1-410	10100	
		Regist		JUL 13 2004			

		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	rtificate of I			giene Reg. No?	16 2204
Physici /Medic		1. Decedent's Name (First, Middle, Las Ana-Maria Valencia	1					Day 2004	
Examin	er	4a. Fecility Name (If not institution, give Holy Cross Hospita 5. Social Security Number 6. Se	1	(In yrs. last birthday)	Silver S	r Location of Death Spring If Under 24 Hrs.		4c. County of	omery
Funeral Director			_M 2X0F	50 Yrs.	Months Days	Hours Min.	Jan. 6,	(, Year)	9. Birthplace (State or F Country) Peru
nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinat must be notified at	Completed by Funeral Director	10a. State 10b. County Maryland Montgome 10e. Street and Number 1402 Caddington Av 11. Marital Status 12 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12)	7enue 12. Was Decedent E Armed Forces? 1 Yes Was Give Year or Dates: ucation de completed) College (1-4or 5	o 16a. Dece (Give life.	ring 10f. Zip Code 20901 Was Decedent of H If Yes, specify Cuba 1 XYes 2 No dent's Usual Occup, kind of work done of DO NOT use retired	Specify: Per	pecify Yes or No- o Rican, etc.) uvian	Specify: 16b. Kind of Bus Internat	American Indian, k, White, etc. White siness/Industry tional
ental Hygie ked other t ic event, th	e	17. Father's Name (First, Middle, Last) José Valencia Cuad	5 + Iros	Econo		18. Mother's Nam	ne (First, Middle,	Monetary Maiden Sumame	
Department of Health and Important: If item 27 is many injury or other traumonce.		19a. Informant's Name/Relationship (7 Jose Valencia/brot 20a. Method of Disposition 1 □ Burial 2 [XCremation 3 □ '4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	her Removal from State	20b. Place of Dispr cemetery, cre. W. Arund	matory or other place el Cremat 2. Name and Addres oing Home	on Ave. S ory 20 ss of Facility Crematic	ilver Sp y 12, 04 0	ring, Mu 20c. Location - C denton, ce P.O.	
nysician Medical xaminer tue priigitus tue p	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury that initiated events resulting in death) Last	a. Carcinor Due to (or as a b. Metastas Due to (or as a c.	na of the consequence of):	Stomach	y, such as cardiac	от гезрпатогу атг	esi,	Approximate Interval Between Onset and Dec 7 months
nysicia ne bur		· · · · ·	d						
y the attending iched for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 TNo 9 □ Unknown	d. 23c. If yes, outcome of the control of the cont	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)			23d. Date Moni	o of delivery th Day Yea
gned by the attending be detached for use a	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 [time of death 5 [Other (specify)			Mont	,
i ate has been signed by the attending page 2 should be detached for use a	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XNo 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 [time of death 5 [Other (specify)		1 TY	bacco use contribuses 2X No 3	th Day Yea
n. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant at 9 Unknown ontributing to death bu Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	2 Fetal death 3 [time of death 5 [t not resulting in the unit 2 Tellow 28b. Time of	nderlying cause give	an in Part I. 26. Place of Dea er: 4 □ Nursing H	24a. Was a autops perform 1 Types the (Check only or ome 5 Reside	Moni bacco use contrib es 2X No 3 in 24b. W es por	th Day Yea bute to the cause of deat 3 \(\text{Probably} \) 4 \(\text{Unk} \) fere autopsy findings avaior to completion of causeath? \(\text{Yes} \) 2 \(\text{No} \) \(\text{Specify} \)
death. ctor: After this certificate has been signed by the attending r the funeral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day) 28e. Place of Injur building, etc.	2 Fetal death 3 Stime of death 5 Stime of death 5 Stime of death 5 Stime of the unit of th	nderlying cause give	26. Place of Dea er: 4 □ Nursing Ho / at ?? Yes 2 □ No	24a. Was a autope perform 1 Yes th (Check only or ome 5 Reside 28d. Describe he 28f. Location (S. City or Town	bacco use contril es 2X No 3 in 24b. W pr de 2X No 1 [es	th Day Yea bute to the cause of deat 3 Probably 4 Unk fere autopsy findings avaior to completion of caus ath? Yes 2 No r (Specify) rd
n. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	ertification; To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injur (Month, Day) 28e. Place of Injur (building, etc.)	The tail death of the unit of	nderlying cause give nt 3 DOA Other 28c. Injury Work M 1 Creet, factory, office	26. Place of Dea er: 4 □ Nursing Ho at ?? Yes 2 □ No	24a. Whas a autopp perform 1 Yes th (Check only or ome 5 Reside 28d. Describe he 28d. Location (S. City or Town and due to the corred at the time, described in the corresponding to the corresponding	bacco use contril es 2\(\frac{1}{2} \) No 3 In 24b. W pr med? 2(2\(\frac{1}{2} \) No 1[22\(\frac{1}{2} \) No 1[ence 6 \(\cup \) Other ow injury occurre treet and Number n, State) ause(s) and man ate and place, ar	th Day Yea bute to the cause of deat 3 Probably 4 Unk fere autopsy findings avaior to completion of caus ath? Yes 2 No r (Specify) rd

			1 - State AMEND ITEM	State of Mar I #19a PER M	yland/[IS. SPA	Depar Res ti	tment of F #8312 3/	lealth and M 16/04 JH	1ental Hy	/giene	001.	22060
	Dhuris		Decedent's Name (First, Middle, La						2. Date of D	eath	V LI LI	3. Time of Death
	Physici /Medio				ALTON		-		July	OS Day	2004	22:07M
	Examir	ner	4a. Facility Name (If not institution, gives	60 5		4	_	r Location of Death	,		unty of Death	
	Funeral		5. Social Security Number 6. S	Sex 7. Age ((In yrs. last bir		f Under 1 Year	If Under 24 Hrs.	8. Date of B	irth		place (State or Foreign
	Director		219-18-7475	1 X M 2 □ F	78	Yrs.	Months Days	Hours Min.	Oct.1	ay, Year) 2 1925	Mary	land
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town	n or Local	tion				1	0d. Inside City Limits
	ith the Marylar or 28a-1 show	ctor	Md. n,	/a	Balti	imore						1 Yes 2 □ No
	with th	Director	10e. Street and Number 567 Brisbane Roa	, d			10f. Zip Code	21229		-	of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show rmst be no lifted at	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Wa	s Decedent of H		acify Yes or N		Race - Americ	an Indian
Maryland 21215-0036	ē ₽ ₹	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:			es, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, ecify: wh	etc.
15-("natu	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	(GIV O KID	t's Usual Occup d of work done NOT use retired	durina most of worki	ing	16b. Kind	of Business/Inc	dustry
212	s within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			oriver	o)		Cab	Compan	v
nd (al Hyg I other	BeC	17. Father's Name (First, Middle, Last,)				18. Mother's Name	First, Middle	1		J
<u> </u>	d 2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, in a Men	To		1ton				Mamie		tner		
Ma	od 2 sh Ith and 27 Is n r traun		19a. Informant's Name/Relationship ((Companion)				and Number or Rura Road, Bal				Code)
Baltimore,	es 1 au of Hea of Hea r Item		20a. Method of Disposition		20b. Place of	Dispositi	on (Name of ory or other place	ce)	Date	20c. Locati	ion - City or To	wn, State
Ĕ	Page ment tant: If		1 ☐ Burial 2 【Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	(y)			ematory		/2004	Balt:	imore,	Md.
Bali	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		21. Sign rune of Funeral Sovice Con	moog2	2		237 E.	ss profesility Polyniak Patapsco	Ave. Ba	altimo:	e P.A.	21225
			23a. Part Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do r	not enter t	he mode of dyin	g, such as cardiac o	or respiratory a	rrest,	,	Approximate Interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Kupti	ured		6min Q	Auto Ar	rengim	•		Onset and Death
	Examiner			Due to (or as a c	consequence o	01):			0			
	p ii	Iner	Sa usintially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence	of):						
_	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence o	of):						
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and vage 2 should be detached for use as the burial-transit			d	,							
	rtificate ng physi as the b	Medical	IF FEMALE:									
Š, ∠, ×	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [Fetal death		topic pregnancy			23d.	Date of delive	ry Day Year
60	that the de ed by the a detached t	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at tim 9☐Unknown	ne of death	5 🗌 O	ther (specify)				Worth!	bay rour
S, P	ires that signed b	by Pl	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the unde	rlying cause give	en in Part I.	23e. Did	tobacco use o	contribute to th	e cause of death?
Sord Condition	w require been sig	ted							1 🗆	Yes 2□N	o 3 Proba	ably 4 Wiknown
Sec	e law i has bo	Completed							24a. Was	psy	prior to con	osy findings available inpletion of cause of
Za ie	Ø 1 <u>⊤</u>	e Co	25. Was case-referred to medical						1 ☐ Yes		death?	2 No
173	× 5	To B	examiner?	Hospital: 1 ☐ Inpatient	2 DER/Out	tpatient	3□ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hor			Other (Specify	•)
Son	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y			28c. Injury Work		28d. Describe			,
- olsi	Attendi death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	9	At home for		M 1 []	Yes 2 □ No	30f Leasties (Character and Mil		
Sign	al or Atten s after death f Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (Specify)	m, street,	ractory, office	4	City or To	wn, State)	imber or Hurai	Route Number,
>	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of ex and manpar stated	camination and	, death oc	curred at the timigation, in my op	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and date and place	l manner as sta ce, and due to	ated. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	MAKE			29c. License			29d. Date sig	gned (Month, L	
	IL		•	" fall	100			8528-3530		July	,08,2	
	101		30. Name and address of person who	laber	b (Item 23a) (100 (Type, Prir	Λ	ue Bal	time	Md	212	.29
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	9	Soones					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death **Physician** Ethel Marie Wilson July 4, 2004 7:50 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clearview Nursing Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 ☐ M 2 💢 F 214-09-2453 93 Director June 9, 1911 West Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at MD Washington Hagerstown 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9946 Downsville Pike or items 23a 21740 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after all Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk retail sales permil. Pages 1 and 2 should be tilk Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traum-siz. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Jasper Brannon Alice Brady ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clearview Nursing Home 9946 Downsville Pike Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street encul 23a. P 11. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Tope Demention ア Alzhem /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ortesporon Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Ho spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier (ON TURE) JULY 5, 2004 D (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 MILL ST MACERITOWN MD ZITMO VASANT DATTA, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registral MEND ITEM	State of M	aryland / ₅	Pen Ce	rtment rtificate	of H	ealth Death	and Me		giene	004	22064													
	Physici		1. Decedent's Name (First, Middle, L.	ast)	Wicks		OME L	. WI	CKS,	an l	2. Date of De		Z 904	3. Time of Death 4 30 AM													
	/Medic Examin		4a. Facility Name (If not institution, gi	oital				ndal	Iston	~n			County of Death														
	Funeral Director			Sex 7. Ag	ge (In yrs. last b	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign ntry) MD													
	he Maryland 8a-f show	Director	10a. State 10b. County MD NA		10c. City, To		ore					10 000		Od. Inside City Limits XXYes 2 □ No													
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. markad other then "natural", or Items 23a or 28a-f show markad other then "natural", or liens 12a or 28a-f show matic event, Ite Marical Exertings at the notified at	by Funerai	3401 Rockdale (11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? Ways 2 Unif Yes, Give Year or Dates:	?		Was Decedif Yes, spec	212 lent of His ify Cubar	spanic Or n, Mexica		ify Yes or No ican, etc.)	- 1	U.S.A. 4. Race - Americ Black, White, Specify: B.	can Indian,													
2121	gas 1 and 2 should be filed within 72 hc at of Health and Mental Hygiene. If item 27 Is markad other than "natur or other traumatic event, Its Madical	0	15. Decedent's & (Specify only highest g Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Las	College (1-4or 3 yrs		(Give life.	dent's Usua kind of wor DO NOT us ntrep	k done d e retired)	eur eur		g (First, Middle,	Who:	d of Business/In lesale tribut(·													
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Baltimore, Ma	pas 1 and 2 s of Health ar of item 27 is or othar trau		Roberta Greave 20a. Method of Disposition XXBurial 2 Cremation 3 4 Donation 5 Other (Spec	S Wicks- □Removal from State	-Wife	340 of Dispo	Roc psition (Nam matory or of	ckda ne of ther place	le	Ct.,	B alti	20c. Loc	e Md 2	21244													
Balti	parmit. Pag Department Important: any injury c		21. Signature of Funeral Service Lice	dnone	P	2	2. Name and	d Addres	s of Facil	ity est	Balt			21215													
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8760,	cate be exacuted physician and the burial-transit	dical	resulting in death) Last	` .	poten	,								Way													
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	41		30. Name and address of person wh		death (Item 23a		Print)	005 D.	695	Pas	adena	الال	M 3, 2	1004													
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			State of Maryland / Department of Health and Me	ental Hygiana
		1 - State	Certificate of Death	0001
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	ysician ledical	Thomas		2. Date of Death Month Pay 2004 11:50 M
	aminer		ution, give street and number) 4b. (City, Town, or Location of Death	4c. County of Death
		tuturecare		n Baltimore
Fun		5. Social Security Number	Months Days Hours Min /	Date of Birth (Month, Day, Year), Country)
Dire	ctor	227-12-1289	Yrs.	(Month, Day, Year) 149.23,1913 Virginia
and *		Usual Residence of Decedent 10a, State 10b, Cou		10d. Inside City Limits
fary!s	à	00 / 1	N/A Deltinosa	1 Yes 2 □ No
the A	100	10e. Street and Number	10// Dain More	10g. Citizen of What Country?
death with the Maryland ms 23e or 28e-f show	instruction to notification	Uno2 R	Bucking Pd 31207	1/2
leath	era era	11, Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	ify Yes or No- 14. Race - American Indian,
fter c		1 ☐ Never Married 2 🕱 M	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri Married 1 ☐ Yes 2 ☑ No	can, etc.) Black, White, etc.
al', o	3 2	3 ☐ Widowed 4 ☐ Divorc	rced If Yes, Give 1 Yes 2 No Specify:	Specify: Rlack
Ind Z I Z I 3-0030 be filed within 72 hours after tak Hygiene. d other than "natural", or Ite	t, the Medical S	15. Deced	dent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working	16b. Kind of Business/Industry
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A bed w		8	1 0 Security Guar	a Private Industry
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VICIF 12 sho 12 sho 12 sho 12 sho	Lie Lie	19a. Informant's Name/Related	ionship (Type, Priht) (Brother-in) 19b. Maling Address (Street and Number or Rural	Poute Number, City or Town, State, Zip Code)
1 and 1 Health	thar	20a. Method of Disposition	20b. Place of Disposition (Name of Date of Dat	9 20c. Location - City or Town, State
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3 - 5 2	njury	* 4 □ Donation 5 □ Other 21. Signature of Funeral Servi	1111 2 011	2004 Lansdowne, Ma.
Depariment of the position of	any ir	MOL	Joseph L. Russ 1	Funeral Home
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		Illiniodiate Cause (Final	13 // 11.	Onset and Death
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Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exam as must be notified a occi-

To Be Completed by Funeral Director

For State Registrar	State of Man		ertificate o			eg. Ne	004	22066				
Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month	DayO	Year	3. Time of Death				
Catherine Estel		eim			July	1	2004	1:53 PA				
i. Fecility Name (If not institution, give		1 Center	4b. City, Town	n, or Location of Deat Utimo re	h	4C. CO.	unty of Deet	h				
Social Security Number 6. S	ex 7. Age (i	In yrs. last birthday,	/) If Under 1 Yea	ar If Under 24 Hrs		*****	9. Birt	hplece (State or Foreig				
14-20-6395	□M 2QF 91	Yrs	Months Day	ys Hours Min.	(Month, Day, 01/28/19			ryland				
sual Residence of Decedent Da. State 10b. County		0c. City, Town or L	ocation					10d. fnside City Limits				
		-						1 □ Yes 2 No				
MD Baltimor De. Street and Number	<u>re</u>	Edgemer	10f. Zip Code	10	1	0g. Citizen	of What Co	ountry?				
7817 North Cove	≏ Rd.		2121			USA						
I. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	. Was Decedent o	of Hispanic Origin? (S Cuban, Mexican, Puer	specify Yes or No-		Rece - Ame Black, White	erican Indian,				
1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ N		(O Piroun, S.m.,		ecify:					
3 ☑ Widowed 4 □ Divorced	Year or Dates:	163 Dec					W]	hite				
15. Decedent's Ed (Specify only highest gra	ide completed)	(Give	edent's Usual Occ re kind of work dor DO NOT use reti	cupation one during most of wo tired)	rking	16b. And .	of Business/	Industry				
Elementary/Secondary (0-12)	College (1-4or 5+)	Sale				Ret	ail					
7. Father's Name (First, Middle, Last)	l			18. Mother's Na	me (First, Middle, I	Maiden Sur	mame)					
Ernest Wri	aht			Mildre			Compt					
9a. Informant's Name/Relationship				eet and Number or R				Zip Code)				
arcro min	(daughter)			ove Rd. Ed	-							
	Removal from State	20b. Place of Disp cemetery, cre	osition (Name or ematory or other p	place)	Date	20c. Locati	ion - City or	Town, State				
		1 Burial 2 Coremation 3 Removal from State 1 Donation 5 Other (Specify) Hilltop Service Corp. 07/12/2004 Towson, MD.										
		TITTTOD	Service	Corp. 07	/12/2004	TOWE	Dain	The The				
Sonature of Funeral Service Liter	1500	Ω 0 $ ^2$	22. Name and Add	dress of FacilityDu	la-Ruck F	.H. 0	f Dun	dalk, Inc.				
Ma-C	· Cans	QQ $\frac{1}{2}$	22. Name and Add	ddress of FacilityDurse Ave. Dur	da-Ruck F ndalk, MD	.н. о	f Dun	dalk, Inc.				
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Page 12 Page 12 Page 13 Page 14 Page 14 Page 15 Page 1	plications that caused the one cause on each line. a. Shoke Due to (or as a complete to for a complet	pregnancy Fetal death 5 not resulting in the	22. Name and Add 7922 Wis- nter the mode of d Comparison of the mode of d Comparison o	ancy given in Part I. 26. Place of De Other: 4 \(\) Nursing is	23e. Did tol 1 Ye 24a. Was a autopoperform 1 Yes 2	23d.	Date of del Month Contribute to death? 1 Yes	Approximate Interval Between Onset and Death Death Onset and D				
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State Registrar

			1 - For State Registrar	State of Mary		artment of I			iene	22067
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deal Month	Day Year	3. Time of Death
	/Medi	cal	Frank J. Winter					July	9, 2004	5:30 A M
	Examir	ner	4a. Facility Name (If not institution, give 9 Bradbwry Road	street and number)			or Location of Deat	n	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year		8. Date of Birth	Baltimo 9. Bir	
	Director		217-05-6821	M 2□F 84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 2	1.1919 Ma	thplace (State or Foreign buntry) TYLANd
	pu 🔭		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or Lo					
	Aanyle Fehor	ō	Maryland Baltimore							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the 128a-	rect	10e. Street and Number	-	OWA	ngs Mill	<u>s</u>	1	Og. Citizen of What Co	1 Tyes 2 No
	h with	Funeral Director	9 Bradbury Road				1117		U.S.A.	· · · · · · · · · · · · · · · · · · ·
	ems a	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.		Hispanic Origin? (S ean, Mexican, Puerl	pecify Yes or No-	14. Race - Ame	
36	or It	by Fu	1 Never Married 2 Married	1 X Yes 2 No		1 ☐ Yes 2 X No		o riioani, oto.)	Black, White	White
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-1 ehow ont, Ite Medicel Exar is writinal by rediffied at	ed b	3 X Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates: WW	II	dent's Usual Occup	nation		16b. Kind of Business	
215	nin 72 na na Medis	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of world)	king	Self-Empl	
21	filed with Hygiene. ther than	Completed	12th Grade	College (1-401 54)		Owner			Bar Owner	
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Maryland 2121	d2st th and t7 is n		19a. Informant's Name/Relationship (Ty) Mr. George Winter	•					City or Town, State, 2	
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumatic event, It a Medical Examination in the modified at		20a. Method of Disposition	2		sition (Name of natory or other pla	oad, Owir		MD 2111 20c. Location - City or	
E O	Z Hen		1 XBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	comatary, croi Sacred He	natory or other pla Lart of J	esus 7/1:	2/2004 F	Baltimore,	Manuland
Baltimore,	permit. Pag Department Importent: any injury once.		21. Sign pur of Funeral Service License) 22	. Name and Addre	ess of Facility Sc.	himunek F	uneral Hon	10 A
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п			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	90.	1	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
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8760,	ate hy:	Physician/Medical	d							
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Box.	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	y		Month	Day Year
P.O	at the de by the tached	hys	9 Unknown	9L Unknown						
	res that igned b be deta	by P	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to	
Vital Records,	w requir been si should I	ted						1 🗆 Ye	s 2 No 3 Pr	obably 4 Unknown
Sec.	e law has b	Completed						24a. Was ar autopsy	/ prior to d	topsy findings available completion of cause of
alF								perform 1 ☐ Yes 2	death? ☐No 1☐ Yes	2□ No
Ĭ	5 6 E	o Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	ospital:	2 ☐ ER/Outpatien	Oth		th Check on one		
		H-0	27. Manner of Death	28a. Date of Injury	28b. Time of	t 3□ DOA 28c. Injur Wor	y at	28d. Describe ho	nce 6 Other (Spec	erfy)
ioi	Attending Fir death. ector: After by the funer.	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury		Yes 2 □ No			
Division	of or Attendated after death Director:	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)		eet, factory, office		28f. Location (Str. City or Town	eet and Number or Ru , State)	ral Route Number,
	spitel or ours afte neral Dire (illed in I	O								
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my ner: On the basis of exa- and manner stated.	rknowledge, death mination and/or inv	occurred at the tire restigation, in my o	ne, date and place pinion, death occu	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	,		29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
)			David Si	wen Do.		H4	3 234	3	ruly 9,	2004
	KHI		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	1	1	11	4.0
	011		DAVID SILV	ER DO	350	1 Eus	Tern	AV, BO	altimore	174.
	Sta Registr		31. Date filed (Month, Day, Year) JUL 13 2004	32 Registrar's 5	oignature &	South	,	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NINTERS Month 5 HARLES 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death MERCY HOSPITAL BALTIMORE AT If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Yrs MARYL Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits PARKVILLE MARYLAND BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2419 ERRING WOODS RD 12. Was Decedent Ever in U.S. Amed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: \%23~67 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SERVICE WNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WINTERS TEORGE FLMER DROTHY 19b. Mailing Address (Street and Number or Rufal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2419 PERRING WOODS RD, BALTIMORE MD 21234 ace of Disposition (Name of 20c. Location - City or Town, State WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JULY 12,2004 PARKVILLE, MD PARKWOOD CEMETERY 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Service Licensee ROSO Jayou 8800 HARPORD RD, PARKVILLE, MD 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner attending physician and for use as the burial-transit has been signed by to 2 should be detach certificate Vital tha Hospital or Attanding Physician: After within 24 hours a To tha Funaral C

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Itams 23a

Pages 1 and 2 should be filed within 72 hours after conent of Health and Mental Hygiene. nnt: If itam 27 is marked other than "natural", or Itar

Department of Health a Important: If itam 27 is any injury or othar traignts.

Priysician

Baltimore, Maryland 21215-0036

traumatic avant, the Medical Examiner must be notified at

Funeral Director

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

death with the Maryland

Registrar

29b. Signature and itle of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pangyoti

29a. Certifier

(Check only one)

aKIS 32. Registrar's Signature

Calvin 04-0451		ns	Please T	ype or Print in B State of Maryland					_	
RJ			For State Registrar	State of Maryland		rtificate of		Reg.	0001	22060
		2.7	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medica		CALVIN		WA	TKINS	JR.	July 9,	2004	10:00 P _M
	Examine	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Balt	r Location of Death		4c. County of Death	/^
*	unanal	2	Johns Hopkins Bayvi		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
	uneral irector			M 20 F 2:	5 Yrs.	Months Days	Hours Min.	OCT. 25: 1		RYLAND
and	W		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation		*	1	Od. Inside City Limits
Магу	ir sho	ţō	MARYLAND N	1A		B	ALTIM	ORE C	ITV	1⊠Yes 2□No
th the	or 288	Director	10e. Street and Number			10f. Zip Code			Citize of What Cour	ntry?
ath wi	3 236 unit	ig.	4301 SEID	EL AVEN	UE		21206	2	USA 14. Race - Americ	nan Indian
ter de	Itam	Funerai	11. Marital Status 1 XNever Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No		14	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White,	
Maryland 21215-0036 to 2 should be lited within 72 hours after death with the Maryland	- le	ò	3 Widowed 4 Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No	Specify:		Specify: BL	ACK
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121 within	than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DRIVE		PA	RECISION	CLEAN
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arylan should be	is marked other then aumatic event, Ire M.	2	CALVIN	WATKI			SHEL	IA	Mo.	RR15
Mar 12 sh	7 is m traum		19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street		I Route Number, Ci	ty or Town, State, Zip	Code)
re, N	Important: If itam 27 any injury or othar tr		20a. Method of Disposition	(MOTHER)	ace of Dispo	osition (Name of		ate 20c	. Location - City or To	own, State
Baltimore, permit. Pages 1 ar	nt: H i		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	metery, crei	matory or other place	ME 07-1	5-04 L	ALIREL M	IARVI AND
Baltim permit. Pag	Importa any inju		21. Signature of Funeral Service License	98 M -	22	2. Name and Addre	ss of Facility RO		-UNERA.	LHOME
m & &	2 5 5 8		Wietrich!	V. Willian	000	2140 N.	FULTON	AVE. BI	ALTO, MD	,21217
	\$		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death	. Do not ent	ter the mode of dyin	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
400	/sician ledical		disease or condition resulting in death)	Due to (or as a consequ	MOUN	03 (2)04	CMESTAWDA	BOOMEN L	ATH COMPL	ICATIONS
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70	# * *	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):					
), executed	n and ial-transit	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consequ	ience of);					
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Box eath cert	ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal	death 3[Ectopic pregnancy	/		23d. Date of delive Month	ery Day Year
O. It de	ed by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)		anara erase		
G. that	00 0	by Ph	Part II. Other significant conditions con	tributing to death but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
rds	been sign should be	ed b						1 ☐ Yes	2 (70) 3 □ Prob	ably 4 Unknown
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A H	certiticate has birector, page 2 s	Con						performed		2 🗆 No
Vita	certiti	o Be	25. Was case referred to medical examiner?	lospital: 1X Inpatient 2 🗆		oth Oth	26. Place of Death			
	er this	—	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	IL SEL DOA	v at	Od Dososibo bow i	6 ☐Other (Specifinity occurred	
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Division Hospital or Attending	Diractor:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify)	•	1	28f. Location (Street City or Town, St	tand Number or Rura tate) 56 23 Y	Bowleys
pital c	aral D		29a, Certifier 1 ☐ Certifying Phys	sicien: To the best of my know		and Lut	ne date and place	LANK BA	ZT, MINE	~3
Div To the Hospital or A	within 24 hous aren beau. To the Funaral Director: After this certificate ha completely tilled in by the funeral director, page	Medicai		ner: On the basis of examinat and manner stated.						
To the	сощр	Me	29b. Signature and title of dertifier	1 //		29c. Licens	e number		Date signed (Month,	
	\		· //	1 for		OCM.	Œ	Ju	ly 10, 200)4
	Ve		30. Name and address of person who co	mpleted cause of death (Item 2 PPLS N	23a) (Type.	11 Penn S	Street, Ba	ltimore,	Maryland 2	21201
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	books				
DHMH 1	Registra 17 Rev 1/20	-	JUL 1 3 2004	General L	1 4	vous		<u></u>		

			1- For State of Ma	ryland / Department of Health Certificate of Death	h	giene 004	22070
	Physic		1. Decedent's Name (First, Middle, Last) SEHTRICE	WINGATE	2. Date of Dea Month JULY	th Day Year	3. Time of Death 02: 45 A M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		4c. County of Death	
			Johns Hopkins Bayview Medical			n/a	
	Funeral Director		5. Social Security Number 124-26-4978 6. Sex 1 M 2X F 7. Age	(In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hours	Min. (Month, Day	(Year) Cou	place (State or Foreign ntry) VYork
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location 7			10d. Inside City Limits
	with the Maryland e or 28a-f show Le notified at	tor	Md. n/a	10c. City, Town or Location 7 Baltimore	1		Y∑Yes 2 □ No
	or 28s	Oirec	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?
	s 23e	rail	1234 Patapsco Street	21230		USA	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28a-1 show any injury or other treumatic event, it with olds! Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:	If Yes, specify Cuban, Mexica		14. Race - Ameri Black, White, Specify: W	
5-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during mo	est of working	16b. Kind of Business/In	dustry
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ylan	12 should be filed within ' h and Mental Hygiene. 7 Is marked other then "r freumatic event, It eth	To B	Jan Lanicek		Josephine	Sadera	
Maryland	d 2 shoth and the and the mand treum		19a. Informant's Name/Relationship (Type, Print) Richard Wingate (husbar	19b. Mailing Address (Street and Numb		City or Town, State, Zip	
re,	ts 1 and Heal		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or To	
Baltimore,	Pages ment or ant: If i		1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bayview Crematory			
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee	22. Name and Address of Facil	k Avenue 1	Baltimore,	
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death. Do not enter the mode of dying, such as	s cardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
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	ted sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	N.S.		
oʻ	execu an and rial-tra	Examin	trial initiated events	consequence of):			
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P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Fetal death 3 Ectopic pregnancy		23d. Date of delive Month	Day Year
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the bass of and manner state and manner state	my knowledge, death occurred at the time, date an examination and/or investigation, in my opinion, dead.	nd place, and due to the ca ath occurred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To th within To th comple	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, I	
	0		Mitesh Dexi, MD	Res-00	00	July 10, 2	004
	3	1	30. Name and address of person who completed cause of dea Mitesh Desci, MD-Johns Hopkins Bays	th (Item 23a) (Type, Print) 4940 Eas	tern Avenue	, Baltimore, N	laryland 21224
	Sta Registra	e	31. Date filed (Month, Day Year) 32. Registrar	s Signature & Sports			-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. Nó) 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nendt Year 2004 4b_City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Hospital The John HOPKINS N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number Months Days Hours 1 XM 2 ☐ F Yrs 216-55-9337 July 15. 1999 United States Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7505 Iroquois Avenue United States 21219 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Timothy Lee Wendt Lynda Lea Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7505 Iroquois Avenue, Edgemere Maryland 21219 Lynda Carr, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 07-13-2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 1050 York Road 1005 Memina Ruck Towson Funeral Home, Inc. Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that raught the shock, or heart failure. List only one cause of each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Nedalloblastoma t years disease or condition resulting in death) Wleeding months 1007+COINTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): leurologic Due to (or as a consequence of): 2 weeks 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 1 Tyes 2 PNo 26. Place of Death (Check only one, Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

The law requires that the death certificate be executed use as the burial-transi Division of Vital Records, P.O. Box 68760, attending physician signed by the al d be detached fo ed by the

page 2 completely filled in by the funeral director,

certificate

After 1 or Attending

death.

after death

within 24 hours a To the Funerel I

Examiner

Completed by Physician/Medical

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Certification;

Medical

State

Registrar

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?7 is marked other than "neturel", or items 23a or 28e-f show traumatic event, the Medical Exams are must be rediffied at

Hygiene.

12 should be filed want and Mental Hygiel

. Pages 1 and 2 should be thent of Health and Menta tant: If item 27 Is marked

other

injury or

Physician

/Medical Examiner

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

determined

6 ☐ Could not be

25-000

balto, MD

W. Adam Gower 600 M Wolfe St

32. Registrar's Signature

31. Date filed (Month, Day, Year) 3004

rocks

sician	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar AMEND ITEM #!&19a PER PHY& Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Date of Death Date of	y Year	3. Time of Death	
edical	Marie Marie P. Zambrzycki As Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c	: County of Death	10:40 4 m	
miner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. 4c. 4c. 4c. 4c. 4c. 4c. 4c	. County or Dough		
ral or	5. Social Security Number 212-12-7047 1 M 2 T 96 Yrs. Social Security Number 1 Min. Months Days Hours Min. June 29, I	9. Birth Cou 1908 Pol	place (State or Foreign ntry) .and	
	Usual Residence of Decedent		10d. Inside City Limits	
ō	10a. State 10b. County 10c. City, Town or Location Baltimore		1X Yes 2 ☐ No	
Funeral Director	10e. Street and Number 10f. Zip Code 10g. Cit	tizen of What Cou	ntry?	
a D	322 S. Chester Street 21231	USA		
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Ves 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Ves 2 No Specify: 1 Yes 2 No Specify:	14. Race - Ameri Black, White Specify: wh		
ea by	15 Decedent's Education 16a Decedent's Usual Occupation 16b, K	(ind of Business/Ir		
Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) [Give kind of work done during most of working life. DO NOT use retired)			
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10 Be	17. Father's Name (First, Middle, Last) Joseph Zebrowski 18. Mother's Name (First, Middle, Maider Pauline Zebrowsk			
	19a Informant's Name/Relationship (Type, Print) (19b Mailing Address (Street and Number or Rural Route Number, City of CEDIFFREX J. BAIN (nephew)		p Code)	
	322 S. Chester Street Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. L.	ocation - City or T	231 own, State	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 2 ☐ Cremation 5 ☐ Other (Specify)			
	21. Signature of Funeral Sarvice Licensee Ronald S. Wade Director State Anatomy Board 655 W. Ballimore, MD 21201	1timore	Street	
i i	23a. Pail 1. Enter the disease, of comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Approximate Interval Between Onset and Death U day S	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		7 years	
Ical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		7 1845	
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 SeNo 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	23d. Date of delik Month	very Day Year	
þ	-		the cause of death?	
Completed	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of	
Con	performed? 1 □ Yes 2 € No.	o death?	2 No	
Be	25. Was case referred to medical examiner? Hospital: Inc. of Decide Check only one) Other: Other: The size of Decide Check only one)		P	
Ilon: To	27. Manner of Death 1 Separate Solution	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred		
Certification:	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office 28f. Location (Street al	f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s and manner stated.	s) and manner as nd place, and due	stated. to the cause(s)	
10	29b. Signature and title of certifier 29d. Disconse number 29d. Disconse	ate signed (Month	, Day, Year)	
Medical	1 / / / / / / / / / / / / / / / / / / /	uly 3	2004	
Medi	29c. License number 29d. Da			

DHMH 17 Rev 1/2001

ORIGINAL

			State of Mar 1- State Registrar Amend#15,18,perFH,FCI				_	giene Reg. No() () ()	11. 220 72
	Physici	ian	Decedent's Name (First, Middle, Last) ELIZABETH G	ANGEL			2. Date of De Month	Day	Year
1	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Tov	vn, or Location of De	June June	27, 2 4c. County	004 1:15 A ^M
	Examina		Frederick Memorial Hos	pital	Fred	lerick		Fred	erick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Y	ear If Under 24 H ays Hours M	rs. 8. Date of Bir	th 19, Year)	9. Birthplace (State or Foreign
	Director	Į .	250-30-3637	88 Yrs.			Jun 15	, 1916	Indiana
	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show deal Example in the motified in	2.		oc. City, Town or Lo	ecation				10d. Inside City Limits
	the M	Funeral Director	10e. Street and Number		10f. Zip Co	de		10g. Citizen of W	
	3a or	<u></u>	17904 Lafayette Drive		101. 210 00	20832		U.S.	
	death	nera	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No		- American Indian,
99	or Ite	F	1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No		ires,speciny 1⊡ Yes 21X0		erto Hican, etc.)	Specify:	k, White, etc.
8	hours urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					101	WHILE
15	n 72 "net	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual O kind of work d DO NOT use n	one during most of a	vorking	16b. Kind of Bu	siness/Industry
21215-0036	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			d Nurse		Health	
	other vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle,	Maiden Sumame	Scherzinger
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-f show or other treumetic event, the Wedical Examples into the mortified at	To B	Ezra Stanley	Gerig		1,036			er zinger
Nar	12 shu and r Ism reum		19a. Informant's Name/Relationship (Type, Print)			reet and Number or			
	1 and Health em 27		Mr. Paul H. Angel, Jr/Husba	20b. Place of Dispo		yette Dri	ve, Olney		nd 20832 City or Town, State
Baltimore,	permit. Pages 1 and i Department of Health Importent: If item 27 any injury or other tr once.		1 🛱 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other	r place)			
Ë	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee			ery Jun 3	0,2004	Fort Way	yne, Indiana
Ba	permit. Departr Importe any inju		N/O	20706	Keeney	√& Basfor	d P.A. Fu	meral H	ome
			23a. Pant. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line.		JO LAST er the mode of	dying, such as card	t, Freder	rick, Mai	cyland 21701
	Physician		Immediate Cause (Final	Last	1	111	2 7-		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a condition at the	consequence of):	hal	USSTA	500	24	day
	Examiner		Sequentially list conditions						•
	P #	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
	and and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a c	onsequence of).					
8760,	cate be executed obysician and the burial-transit	aE	555 (5) (5) 43 4 5	onsaquence or).					
687	ficate phys s the	edical	d						
Box (eath certific attending p	Z/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d Date	of delivery
P.O. Bo	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physiclan/M	in the past 12 pronths? 1		Ectopic pregn Other (specif			Mon	
	that in the property of the pr		Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying caus	e given in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
Records,	w requires been sign should be	ed by	Vighter Melli	tac- 1	4/20	71	101	res 3000	3 Probably 4 Unknown
000	s bee	Completed	Stille	,	//		24a. Was		/ere autopsy findings available
æ	The lite ha	mo					- autop perfo 1 ☐ Yes	rmed? de	rior to completion of cause of eath? □ Yes 2 □ No
Vital	sicien: The law scertificate has b irrector, page 2 s	Be C	25. Was case referred to medical examiner?			26. Place of D	eath (Check only o	7	
of V	Physicien: this certificanal director,	10	1 Yes 2 No Hospital: Hopatient	2 ER/Outpatien	t 3 DOA	Other: 4 Nursing	Home 5 Resid	ience 6 🗆 Othe	r (Specify)
n c	Ing P		27. Many or of Death 28a. Date of Injury 1 € Matural 5 Pending (Month, Day Y	(ear) 28b. Time of Injury		Injury at Work?	28d. Describe h	now injury occurre	ed
sio	tendi leath. tor: A	cati	2 Accident investigation			1 ☐ Yes 2 ☐ No			
Division	s after of all Direct of all Direct of or by	Certification;	4 Homicide determined 28e. Place of Injury building, etc. (At home, farm, stre Specify) 	eet, factory, of	fice	28f. Location (5 City or Tox	Street and Numbe vn, State)	r or Rural Route Number,
	To the Hospitel or Attending Physicien: The Is within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of real network of the basis of examiner: On the basis of examiner and manyer stated	amination and/or inv	occurred at the	ne time, date and pla my opinion, death oc	ce, and due to the courred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To th withir To th compl	Me	29b. Signature and fitte of certifier	enc.	29c. Lie	cense number		29d. Date signed	(Month, Day, Year),
			· Came Ca	~	D	1642 8		6/2	27/14
	5		30. Name and address of person who completed cause of deat			Charles T		M- 3	1 04704
		to.	Casper E. Clihe, III, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's		MINTH	otreet, F	rederick,	Marylar	na 21/01
35	Sta Registr		JIM 2 9 2004 1544	- A	1	2. 11 1.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Barbara Jean Beach /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LSH Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Mary Tand 213-42-1800 60 Director Aug. 7,1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23e or 28e-f show the Medical Examiner must be notified at Falling Waters West VA. Berkeley 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25419 USA 186 Antietam Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) Ribbon Manufacturer 12 Supervisor 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any july or other traumatic event other. Be Inez Irene Faulders ္က Harold Dill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Falling Waters, WV 25419 Joseph Beach/Husband 186 Antietam Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park June 15,2004 Hagerstown, Maryland `4 Donation 5 Dother (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signatural Source 425 S.Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Keup **Physician** Week /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner use as the burial-transit Acoustic The law requires that the death certificate be executed signed by the attending physicien and is be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 MNo Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Wellumites 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown COMA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy this certificate has 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 1346

State Registrar

DHMH 17 Rev 1/200

as is per ME

JUL 1 3 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

on my his liversity

32. Registrar's Signature

....

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryland	•	artment of H			giene Rog. No.2 () () 1	22075
	A. 1	颗	Decedent's Name (First, Middle, Last,					2. Date of De	ath	Vanc	3. Time of Death
	Physicia	100	George Brooks					June :	18 2004	Year	6:00 a ^M
)	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of	f Death	
			1120 Madison St	reet Apt. 3		Annapol:			Anne A		
0. [1]	Funeral		5. Social Security Number 6. Security Number 1.	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Coun	
	* Director		214-72-1033 Usual Residence of Decedent	45	113.			June 2	1 1958	Mar	yland
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Mary Fied	ţ	Maryland Anne A	rundel Anna	apol:	is					1 XYes 2 No
	r 28e	Director	10e. Street and Number			10f, Zip Code			10g. Citizen of W	hat Cour	ntry?
	th wit	aiD	1120 Madison St	reet Apt. 3		2140				USA	
	ems er m	Funerai	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puer	ipecify Yes or No to Rican, etc.)		- Americ , White,	an Indian, etc.
36	or it	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 21 No If Yes, Give Year or Dates:		1 ☐ Yes 2 █ No	Specify:		Specify:	B1	.a c k
Ö	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28e-f show hedical Evaninar must he notified at	q pa	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	siness/Inc	dustry
21215-0036	n na	Completed	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	during most of wo l)	rking			·
212	d with giene	mo:	Elementary/Secondary (0-12)	0	S	elf Empl	Loyed		La	abor	er
힏	e file al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)						, Maiden Sumame	1)	
<u>la</u>	Ments Ments arked	으	Jeremiah Bro	oks				lagget			
Jan	2 sho	0 1	19a. Informant's Name/Relationship (T)			ng Address (Street					
e co	l and lealth im 27 ther ti		Ruth Cook (Sist			Cedar I	Ridge C	t. Anna	20c. Location - (
וסר	toff:		1. Burial 2 ☐ Cremation 3 ☐ I	Removal from State H i 1 1	netery, crea	es Memo	rial .	25/04	Annapo	•	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23a or 28e-f show importent: If item 27 is marked other than "naturel; or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ange.		 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens 		2:	2. Name and Addres	ss of Facility	25/04			
Ba	Departiment Department	1 6		42 MOS 483		Wm, Rees	se & So	ns Mor	tuary.	212	101
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not en	ter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Glioblast	DMA	mult-	forme				Onset and Death
	/Medical		resulting in dealh)	Due to (or as a conseque							O. Z. FJC
	Examiner		Sequentially list conditions.	ь							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce ot):						
	xecut and il-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):		_			-	
8760,	cate be executed only sician and the burial-transit	dicai E		d							
687	, LL (A	edic		0.							
Вох	eath certifi attending for use as	Physician/Me	23b. was decedent pregnant	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Feta! d		☐Ectopic pregnancy	,		23d. Date		*
	the atter the atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea 9☐Unknown		Other (specify)			Mon	เก	Day Year
P.0	ac by	Phy	9 Unknown		ing in the .	and orbital and a succession	on in Part I	23e Did	tobacco use contri	bute to ti	he cause of death?
ຜົ	S C 90	þ	Part II. Other significant conditions co	intributing to death out not result	ing in the t	inderlying cause giv	on in rait i.	1 🗆	4		pably 4 Unknown
of Vital Record	w requires been sign should be	Completed						24a. Wa		loro auto	ancy findings available
3ec	e la has je 2	mpi			-			auto	psy promed? d	rior to cor eath?	psy findings available mpletion of cause of
a	icien: The l certificate ha	e Co	25. Was case referred to medical				as Blace of De	1 ☐ Yes ath (Check only		☐ Yes	2 No
₹		0 8	eyaminer?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Oth	er		idence 6 Othe	ir (Specif	(v)
		 -	27. Manner of Death		8b. Time o		v at		how injury occurre		
ion	Attending r death. ector: After by the fune	atio	Natural 5 Pending 2 Accident investigation		mjury		Yes 2 □No				
Division	or Attenuatter deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At hom building, etc. (Specify)	ne, farm, st	reet, factory, office			Street and Numbe wn, State)	r or Rura	Al Route Number,
	ipitel or Attenious after deat deat Director:			1				Į.			
	Hos Fur ely	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my know liner: On the basis of examination and manner stated.	ledge, dea on and/or in	th occurred at the til nvestigation, in my o	me, date and plac pinion, death occ	e, and due to the urred at the time	date and place, a	nd due to	tated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. Date signed	2	
			> Xlb4x 40	mualepp,	MD	D	74161		6/20/	200	4
			30-Name and address of person who	completed cause of death (Item 2)	23a) (Type	Print) LCal Pa	busar	4670	Annos	li	MP 21401
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		1	•)	4,7	711.0		
	Regist			2004	K A	park					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. #4c perSpaths of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #10b PER INF G833 7/28 Of till Bate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 7:40 A.M. Elsie 27, Ann English Brown June 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Frederick CARROLL Lorien Health. Systems Mt. Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 89 Yrs. 228-38-4610 Director Oct. 19, 1914 Virginia Usual Residence of Decedent 10b. Count CARROLL be filed within 72 hours efter death with the Marylend 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Depertment of Health and Mental Hygiene.
Important: If Item 27 is merked other than "natural", or items 23s or 28s-f show any hjury or other traumatic event, the Medical Experiment must be notified at once. 10a. Stete 10c. City, Town or Location 1X Yes 2 No Directo Maryland Frederick Mount Airy 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6251 Belmont Circle Funeral 21771 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black White etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 2 3 ₩ Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Clerk Pharmacy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Т. English Amy Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Lindsey/ Daughter 6251 Belmont Circle, Mount Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20b. Place of Disposition of other place)
Williamsburg Memorial
Park 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/04 Williamsburg, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungfal Service Ligenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland Approximate 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical action vascular Discono Examiner Due to (or as a consequence of) Examiner or Attanding Physician: The lew requires that the death certificate be executed ettending physician end for use es the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): ours after death. erat Director: After this certificate has been signed by the e filled in by the funeral director, page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 11.1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Hursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Mospital of within 24 hours of To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D3516 un 30. Name end eddress of person who completed gause of death (Item 23a) (Type, Print) gistrar's Signature 31. Date filed (Month 2 8 State Registrar

			For Stata Ragistrar		State	of Maryl	and / Dep <i>Ce</i>	artmen rtificat				-	giene Reg. No:	004	. 2	2207	7
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	Funeral Director		5. Social Security Num 214-16-61	6.	Sex 1 □ M 2 🛣 F	7. Age (In y	rs. last birthday 2 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da Oct. 5	h y, Year) , 192	9. 1	Birthplac Country	(State or For	eign
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	e Mar	ctor	MD	Anne	Arundel			Se	everr	na Pai	rk					1 □ Yes 2 🔯	No
	with th	Funeral Director	10e. Street and Number 511 Pinet		iro			10f. Zip		21146			10g. Citize	n of What			
	death me 23	eral	11. Marital Status	Tee Di	12. Was De	ecedent Ever i	n U.S. 13.	Was Deced			gin? (Spec	cify Yes or No- Rican, etc.)	- 14	. Race - A		SA Indian,	
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "natural", or iteme 23a or 28a-1 show od other then "natural", or iteme 23a or 28a-1 show event, itte Medical Examitrer roust be profilled at	by	1 ☐ Never Married 3 🔀 Widowed 4 [Forces? s 2 ½ No ∃ive Dates:		If Yes, spec		n, Mexicar Specify:		Rican, etc.)		Black, W pecify:	_	ite	
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Baltimore,	Pages tment of tent; if it		'4 □Donation 5 (Other (Spec	eify)	n State (Glen Hav				June			n Bur			
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	be executed sician and burial-transit	Examiner	any, leading to immediate. Enter Uniderly: Cause (Disease or injust that initiated events resulting in death) Las	ing T	c	o (or as a con:		eunz								24/11	
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<u>ta</u>	cian: ertifica ector, p	Be C	25. Was case referred examiner?	to medical					-158	26. Place	of Death	(Check only of			-		
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	/Medic		Edward Beattie			4b. City, Town, o	!		June	22	2004 nty of Deat	
	Examin	er	4a. Facility Name (If not institution, giv 1015 Norman Driv		2	4b. City, Town, o		polis			ne Ar	
	Funeral		5. Sociat Security Number 6. S	Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under	-	Date of Birt			hplace (State or Foreign untry)
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	or of		20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐		cemetery, c	position (Name of rematory or other pla		Date 6/23/2		20c. Location	more,	
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	certificate has ector, page 2	e C	25. Was case referred to medical				26. Place	of Death (C	1 ☐ Yes	2 2 No	1 🗆 Yes	212(No
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	fter fter	ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time (Year) Injur	Wo	ork?		. Describe I	now injury occ	curred	
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	De Place of Init	ury - At home, farm,		Yes 2 1		Location /	Street and Nu	mhar or Pu	ral Route Number,
2 3	after of Direct of In by	Certificatio	4 Homicide determined	building, etc	c. (Specify)	street, ractory, onice		201.	City or To		inda or rig	TEL PROBLE NUMBER,
	ospita hours ineral y filled		29a. Certifier 1 Certifying P	hysicien: To the best of	of my knowledge, de	ath occurred at the t	ıme, date an	nd place, and	due to the	cause(s) and	manner as	stated.
1	I o the Hospital of Attends within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	miner: On the basis of and manner sta				itii occurred a				
	5 til 5 co	2	29b. Signature and title of certifier	7.2mol2	/		se number	13		29d. Date sig		
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Tur	e. Print)				June	A	2,2004 napolis, Ma
			and the same of th	ROMER	20 13	3 Defen	se this	ghnon	1 Sill	H112	imi	rapais, Ma
	Sta	-	31. Date filed (Month, Day, Year)	32. Registra 4 2004	ar's Signature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elizabeth Barkley JULY 07 2004 1350 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Jul 4, 1917 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 KF Yrs. 217-10-1200 Director 87 Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits in than "netural, or Items 23e or 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 108 Pennsylvania Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "netural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Nursing Assistant Memorial Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beniamin Martin Ella Maude (Inskeep) Martin 2 treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 ls other tree Deborah Coffman daughter Route 2 Box 294 Fort Ashby WV 26719 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 permit. Page Department of Important: If any injury or once. Wesley Chapel Cemetery 7/9/2004 **Points** WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licens 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE YEARS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a someoquenes of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) physician Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. DIABETES MELLITUS, HYPERTENSION, ATRIAL FIBRILATION 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2√∑ No _2√□ No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 Residence 6 □Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Funeral C 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. Within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0054004 2004 JULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 EAST NATIONAL HIGHWAY LAVALE, MARYLAND 21502 DR.SHIV KHANNA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

1 3 2004

			For State Registrar		State of	Marylar		artment of <i>tificate of</i>			1ental F	Hygien Rog. N	200	14	220	080
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255 g) s				BERLY WAY				STEVEN:					QUEEN			
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2-0036	72 ho 'natura	eted	(Spec	15. Decedent's l	Education rade completed)		16a. Deced	ent's Usual Occu kind of work done OO NOT use retire	pation during m	ost of work	ing	16b. I	Kind of Busi	ness/Inc	dustry	
2	within iene. than	Completed	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)		OO NOT use retire OPERAT(ATT	томотт	TVF	SUPPLI	FR
	othe ent.	Be C	17. Father's Name	(First, Middle, Las	it)		TREBE	OI BIUIT		ther's Name	e (First, Mid		n Sumame)		DOLLE	
5	2 should be and Menta Is marked	2	EDMUND B		T 0:0		=			ORA P						
Z	and 2 st ealth and n 27 Is n	1	19a. Informant's Na		(Type, Print) N/DAUGHTE	ER.	1 11	g Address (Stree IMBERLY						ate, <i>Zip</i> 1666		
more,	프로토등		20a. Method of Disp	position	☐Removal from Sta			sition (Name of patory or other pla MEMORIAL			Date	-	ocation - Ci			
Saitim	permit. Pages Department of Important: If i any injury or of once.		* 4 ☐ Donation 21. Signature of 5	5 Other (Spec	ify)	PA		Name and Addr		THE STREET, ST	1/2004	FLA	T ROC	K, 1	(I	
ñ	Dep		16	1 14	. Sh	711	FE	LLOWS, I 6 SHAMRO	IELFE	NBEIN	& NEV	NAM :	FUNER <i>A</i> D 216		OME, P	P.A.
			shock, or hea	rt failure. List only	nplications that cau y one cause on eac	sed the deal	th. Do лot ente	,	\triangle			y arrest,			Approximate Interval Bety Onset and E	ween
ı	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final in	a. Due to for	as a consec	asta	tic (an	2'10	Ma				Onset and E	Jea(11
**	Examiner		Sequentially list on	aditions	b	a3 a consec	tuerice ory.									
	led sit	niner	Sequentially list con any, leading to in cause. Enter Unde Cause (Disease or	nmediate orlying injury	Due to (or	às a consec	uerice of).							11		
	executed an and rial-transit	Examin	that initiated events resulting in death) I		c Due to (or	as a conseq	quence of):									
09/90	ficate be executed physician and is the burial-transit	edlcal		•	d									_	- V	
	certific nding p	/Mec	IF FEMALE: 23b. Was deceden		23c. If yes, outcome	me of pregna	ancy						23d. Date of	of deline	D.	vc. 1
ă	e death cert the attending hed for use	Physician/M	in the past 12 1 Yes 2 Unknown	months?	1⊡Live birth 4⊡Pregnan 9⊡Unknowi	n 2 □ Feta tattime of d	al death 3 🗌	Ectopic pregnand Other (specify) _	у			-	Month			'ear
ŗ	that the		Part II. Other signif		contributing to deat	h but not res	sulting in the un	derlying cause gr	ven in Par	t I.	23e. Di	d tobacco	use contribu	ite to the	e cause of de	eath?
Soras	equires en sign ould be	ed by									1[∐Yes 2	□No 3[] Proba	ably 4 💆 U	Inknown
o e c	The law requires that the attended by the base been signed by the bage 2 should be detached.	Completed									24a. W	topsy	24b. Wei	re autop	sy findings a	vailable luse of
	n: The ificate or, pag	e Co	25. Was case refer	red to medical			-				1 Tes		dea 1 🗆		2□ No	
-	lysicia lis cert directo	ToBe	examiner?		Hospital:	atient 2 🗆	ER/Outpatient	3□ DOA Ott			n <i>(Check onl</i> me 5 ☐ Re		6 Mher	Specify.	Drught	eris
5	ing Ph		27. Manner of Death	h 5 🗌 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	2	28d. Describ			-,,	resid	ence
VISIO	Attend death octor: by the f	Certification:	2 Accident 3 Suicide	investigation 6 □ Could not l determined	28e. Place of	Injury - At h	ome, farm, stre	M 1 =]Yes 2[28f. Location	(Street ar	nd Number o	or Rural	Route Numb	oer.
5	ital or irs after ral Dire		4 🗌 Homicide		building,	etc. (Specif	(y)				City or 1	Town, State	e)			
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours attended. Within 24 hours attended the control of the attending to the function of the attending completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the be miner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred at the ti estigation, in my	me, date a opinion, de	and place, a eath occurre	and due to the ed at the tim	ne cause(s e, date and) and manne d place, and	er as sta due to	ited. the cause(s)	
	Vithir To th comp	⊠	29b. Signature and	title of certifier				29c. Licen:	se numbe		-	29d. Da	te signed (A	Aonth, D	ay, Year)	
1	0		> Non	LC.	y my)		127	273	1			6-	210	-04	′
	Bu		30. Name and address	1 /	completed cause of	or death (Item	п 23а) (Туре, Р / "Д/"	LOUE.	PT	Kel	54	ev-an	S 111	11	e lu	1
	Sta Registra	_	31. Date filed (Mon	JUN'3'0	2004 32. R	istrar's Signa	ature A	mad:			122				211	066

			State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and	Mental H	ygiene Rag. NQ	001	20001
			Decedent's Name (First, Middle, Last)	2. Date of I	Death	JU4-	3. Time of Death
	Physicia		Stanley Czarnecki	Jun e	Day 2 8	Year 2004	2:20 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea			ounty of Death	2,20 F
		•	Anne Arundel Medical Center Annapolis		An	ne Arun	ndel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs			9. Birthp	lece (State or Foreign
	Director	+	12M 2 F 84 Yrs. Months Days Hours Min	May 2		0 Ohio	
	р ,		Usual Residence of Decedent				
	anyla shov	-	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 No
	88-1 1-88	ctc	Maryland Anne Arundel Annapolis				
	or 2	Dire	10e. Street and Number 10f. Zip Code		10g. Citize	n of What Cour	ntry?
	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "naturel", or items 23e or 28e-1 show event, the Medical Examination must be notified at	Funeral Director	2723 Yeomans Lantern Court 21401			d State	
	er de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or I nto Rican, etc.)	No- 14.	 Race - Americ Black, White, 	
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes, Give 1 Yes 2 No Specify: Year or Dates: WIJT T		S	pecify:	
Ş	hour furel		3 ☐ Widowed 4 ☐ Divorced Year or Dates: ₩₩II ☐ 15. Decedent's Education ☐ 16a. Decedent's Usual Occupation		105 Kind	whit	
1 5	n 72 "na e ilic	Completed	(Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most dur	orking	166, Kind	of Business/Inc	austry
72	within ene. than "	mc	Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic		has	+	4
9	e filed within al Hygiene. I other than ' vent, I've Me		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Midd		ting an	id air
Maryland 21215-0036	d be antal	o Be	Adam Czarnecki Eleanor	Blacho	wicz	,	
<u> </u>	2 should be and Mantal is marked c	ပို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			own. State. Zin	Code)
S	s 1 and 2 should f Health and Man item 27 is marke other treumatic		Frances Czarnecki/ wife 2723 Yeomans Lanter				
ā,	Hea Hea tem othe		20a, Method of Disposition 20b. Place of Disposition (Name of	Date	-	tion - City or To	
<u>o</u>	ages int of t: If i		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Lakemont Cemetery July	2 200	Dave		11e, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre	Ì	21. Signature of Funeral Service Licensee	ohn M	Tavlor	Funera	1 Home Too
Ba	permi Depa Impo any ir		2 Scott Romanodu 147 Duke of Glouce	ester S	t. Ann:	anolie	MD 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		4	иротто,	Approximate
8760,	/Medical Examiner b physician and physician and street prival-transit is the burial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	recid	on l		Onset and Death
.O. Box 6	the death certi y the attending iched for use a	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d	d. Date of delive Month	ory Day Year
rds, P	ngi ba	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		(_/	contribute to th	e cause of death?
Il Records,	Tha taw ate has b page 2 st	Completed			s an 2 opsy formed? 22 No	prior to con death?	osy findings available inpletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ath Check onl	one		
o	S S 5	P_		Home 5 Re)
n O	ing F	on	27. Magner of Death 28a. Date of Injury 28b. Time of Injury at (Month, Day Year) 28c. Injury at Work?	28d. Describe	how injury o	ccurred	
sic	Attending r death. actor: Afte by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				
Division	l or At after o Direct I in by	Certification:	4 Homicide 3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and N own, State)	lumber or Rural	Route Number,
	urs a			1			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Check only Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the time, date and place (Check only Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of texamination and/or investigation, in my opinion, death occurred at the check of the check only 2 Medical Examiner: On the basis of texamination and or investigation and occurred at the check of the check only 2 Medical Examiner: On the basis of texaminer (Check only 2 Medical Examiner).	e, and due to the urred at the time	e cause(s) and b, date and pla	d manner as sta ace, and due to	ated. the cause(s)
	the	Med	one) and manner stated. 29b. Signature and the of certifier 29c. License number			igned (Month, L	
	To To Con	-	MD NECLE	77	Lou. Date 9		1
			Mr. 9 110 12518	1	6/2	28/0	/
			30. Name and address of person who empleted cause of death (It yn 23a) (Type, Print)	121	1	3 1	
	Sta	10	31. Date filed (Month, Day, Year). 32. Segistrar's Signature	100110	01/	eniel	V .
	Registr		JUL - 1 2004 James & Specific				

			1 For State	State of Maryland / Dep				2001	22000
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Dea		Reg. N	102 0 0 4	3. Time of Death
	Physici	an		T 0			Month D	ay Year	
,	_/Medio		Pame la 4a. Facility Name (If not institution, give s.	Jo Coope	er 4b. City, Town, or Loca		June 28	2004 tc. County of Death	3:00 A.M
	Examir	ner	11910 Chantilly La		Mitchell:			Prince Ge	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	y) If Under 1 Year If U	Jnder 24 Hrs. 8	Date of Birth		place (State or Foreign intry)
	Director		527-96-0044	M 2∏F 54 Yrs.	Months Days Ho	ours Min.	(Month, Day, Yea June 25,	1950 Cali	ifornia
	D >		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	short strong	5	Maryland Prince Ge		ellville				11 Yes 2 □ No
	28a-1	Director	10e. Street and Number	orges micene	10f. Zip Code		100.0	Citizen of What Cou	21
	with Mark	2	11910 Chantilly La	ne	20721			J.S.A.	2111191
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I.a Medical Exam as mind be inclined at	Funerai	11. Marital Status	2. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispan	nic Origin? (Speci	fy Yes or No-	14. Race - Amer	
٥	or ha		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Me		can, etc.)	Black, White	, etc. White
200	raf, c	d by	3 Widowed 4 Divorced	If Yes, Give X Year or Dates:	TEL Yes 2th No Sp	necify:		Specify:	
	natu dicu	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec completed) (Giv	edent's Usual Occupation we kind of work done during . DO NOT use retired)	g most of working	16b.	Kind of Business/Ir	ndustry
2	within 72 ene. than na	m du	Elementary/Secondary (0-12)	College (1-4or 5+) Hom	nemaker			wn Home	
-	Hygie other ent, it	ပိ	17. Father's Name (First, Middle, Last)	3	18. !	Mother's Name (First, Middle, Maide	an Sumame)	
⊑	ould be Mental larked o	To Be		lemans		Peggy	Ε.	Mille	er
<u> </u>	s 1 and 2 should f Health and Men itam 27 is marke other traumatic	F	19a. Informant's Name/Relationship (Typ		iling Address (Street and N				
Ĕ	and 2:		James P. Cooper/ Hu		.0 Chantilly				
aitimore,	s 1 an of Heal itam 2		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)	Dat	e 20c.	Location - City or T	own, State
Ë	permit. Pages Department of I Important: If it, any injury or o once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Huntt Cr		6/29/	2004 Wa1	dorf, Ma	rvland
<u> </u>	permit. Departn Imports any inju		21. Signature of Funeral Service License	е	22. Name and Address of I				
מ	89889		1 Lott	1	.6000 Annapol	lis Road	, Bowie,	Maryland	20715
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not e a cause on each line.	nter the mode of dying, suc	ch as cardiac or r	espiratory arrest,		Approximate Interval Between
k F	Physician		Immediate Cause (Final disease or condition	METASTATI	C BREAST	CA	NCER		Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
		_	Sequentially list conditions,	Due to (or as a consequence of):					
5.55	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0 (2) 23 2 05/100425/100 (1).					
,	cate be executed physician and the burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequence of):					
8/60	e be /sicia e bur	dicail	d						
200	tificat ig phy as th								
X Q Q	death certificate be executed e attending physician and id for use as the burial-transit	hysician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	Ectopic pregnancy			23d. Date of deliv	,
u	e deal	sicie	in the past 12 months?		Other (specify)			Month	Day Year
	at the d by th etache	Phy	9 Unknown				00 B:44-1		
က်	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions conf	ributing to death but not resulting in the	underlying cause given in I	Part I.		o use contribute to t 2 □ No 3 □ Prof	N
Hecords	requi	eted					1 Yes	2010 3010	Dably 4 DONKHOWN
ခို	elaw hasb e2st	ompieted					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	acian: The lav certificate has rector, page 2	O					performed? 1 ☐ Yes 2 X N	death?	2 🗆 No
VItal	sician certif rector	o Be	25. Was case referred to medical examiner?	ospital:	0	Place of Death (1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3		
0	Phys rthis raldi	-	1 Yes 2 No	28a. Date of Injury 28b. Time	BILL 3 DOA 4		d. Describe how inj	6 ☐ Other (Special	fy)
0	ding th. : Afte fune	tior	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes		,	-,	
DIVISION	Attar r dea actor by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, s	street, factory, office	28	f. Location (Street a	and Number or Run	al Route Number,
5	al or s afte	Certification:	4 Homicide	building, etc. (Specify)			City or Town, Sta	te)	
	To the Hospital or Attanding Physician: within 24 hours after death or To the Funaral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, dea	ath occurred at the time, da	ate and place, and	d due to the cause(s) and manner as s	stated.
	the H in 24 the Fi	ledical	one)	er: On the basis of examination and/or and manner stated.					
	To To	Σ	29b. Signature and title of certifier		29c. License num			ate signed (Month,	
			Aprili MI)		24334	-	6	1-8/04	
			30. Name and address of person who con	mpleted cause of death (Item 23a) (Type	e, Print)	an #	DI CLII	STOAL ML	020735
	-04		31. Date filed (Month, Day, Year)	32. Rigistrar's Signature	JIN RI	ישי שיי	1000	7-70	
	Sta Registi		JUN 2 8 20	104 Januar 15 1	and the				

			1 - For State Registrar	State of Ma	aryland		artmen			and M	_	giene Reg. No			22083	
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	,	Year	3. Time of Death	
	/Medic		Charles A. Cus								June	_21	, 2	2004	2:45a	1
	Examin	er	4a. Facility Name (If not institution, give 104 Cat Tail (1		nsvi			1	County		nnoa	
	Francis		5. Social Security Number 6. Se		e (In vrs. la	ast birthday					8. Date of Bird	th			nnes	1/2
	Funeral Director			XM 2□F	84	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	920	Coun	ace (State or Foreig ry) NJ	"
	P .		Usual Residence of Decedent								100.	1 -				
	show	'n	10a. State 10b. County		10c. City	, Town or L								10	d. Inside City Limits	
	Ne M	Director	MD Queen A	nnes			-		ensvi	ш					1 ☐ Yes 2 ₩ No	_
	with i	Dir	104 Cat Tail Cour	rt			10f. Zip	216	566			10g. Cit		hat Count USA	ry?	
	ms 23	era	11. Marital Status	12. Was Decedent E	Ever in U.S	S. 13	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)	-		- America	ın Indian,	_
စ္	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show int, It a Medical Exacultational be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	10					i, Puerto	Rican, etc.)			k, White, e	white	
8	ural',		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WW	II	1 ☐ Yes 2	- 24 140	Specify:				Specify:		WIII CC	
<u>5</u>	"nati	lete	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dec	edent's Usua e kind of wor DO NOT us	k done	ation during mos	t of worki	ng			siness/Ind	ustry fice	
12	withii iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		ostal						Jers		.1106	
פ	a filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame	-		_
<u>Jar</u>	Menta Menta arked	To E	Vincenzo Cusumar	10					Mar	cia F	'ederic)				
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiens. If item 27 is marked other than "natural", or litems 23a or 28a-1 show if item 27 is marked other than "natural", or litems 23a or 28a-1 show or other traumatic event, II as the litems at the notified at		19a. Informant's Name/Relationship (7) Carmela M. Cusum								I Route Number			State, Zip		
ე	1 and Healt tem 2		20a. Method of Disposition		20b. Pl	ace of Disp	osition (Nam	ne of	1	D	ate		•	City or Tov		-
Ē	Pages nent of I ant: If its arry or o		IM☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		MD	Vetei	matory or ot cans 's	ther plac Cen	etery	. Ju 7 2	ne 25, 2004			ille,		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Euneral Service Licens	BB A/L	\neg	Í	Sarran 195 Go	d Addres CO & V. R	Sons Sitchi	P. e Hw	A. Seve	erna erna	Park Park	k Fur	eral Home 21146	3
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused ne cause on each lin	the death	. Do not er	nter the mode	of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a C1	1+										Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	a consequ	ence of):										
		er	Sequentially list conditions, if any leading to immediate	b. Due to (or as a	a cons u	ence of):										_
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
ó	an an rial-tr		resulting in death) Last	Due to (or as a	a consequ	ence of):								_		_
8760,	cate be executed physician and the burial-transit	dicai		±												
9	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as t	/Мес	IF FEMALE:	23c. If yes, outcome of	of pregnar	acv.										
Вох	atten for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at	2 ☐ Fetal	death 3	□Ectopic pre					4	23d. Date Mont	of deliver	y Day Year	
o.	that the de ed by the a detached t	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		u		JONY								
o, o	es that igned b	by Pi	Part II. Other significant conditions co.	atributing to death bu	ıt not resu	lting in the	underlying ca	use give	n in Part I.		23e. Did to	obacco u	se contrit	oute to the	cause of death?	
ğ	w require been sig should b										1 🗆 Y	'es 2[]No 3	B □ Proba	bly 4 Onknown	
Record	e taw re has bei je 2 sho	Completed									24a. Was autop		24b. W	ere autop	sy findings available pletion of cause of)
		Com									perfor	rmed?_	de	ath?		
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	1							(Check only o					
	this aldi	10°	1 Yes 2 No	lospital: 1 ☐ Inpatier 28a. Date of Injury		R/Outpatie					ne 5 Resid					_
o	ding I h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	M 20	3c. Injury Work 1 □ 1	(? (es 2 □ !		.od. Describe n	iow injur	/ Occurred	u		
Division of	r Attener deatl	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At hor	ne, farm, si					8f. Location (S			or Rural	Route Number,	-
ā	s afte	Certification;	4 Homicide	building, etc	. (Эрөспу,	,					City or Tow	m, State,	1			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best o ner: On the basis of and manner stat	examinati	/ledge, dea on and/or in	th occurred anvestigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurre	and due to the ded at the time, d	ause(s) date and	and manr place, an	ner as sta nd due to t	ted. he cause(s)	
	To the within To the comp	Ž	29b. Signal of and title of certifier	11.0			29c.	License	number					(Month, D		
			He V Houle	er ill			11	40	118			06-	-22-	200	4	
			30. Name and address of person who co			23a) (Type	Print)	Mac	rdoli	s Ar	17 219	ful	1			
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 5 20	32 Penistra			hands o		4		, , ,					-
	riegisti	£11		1		17										

			4 101	partment of Health and Mer ertificate of Death	ntal Hygien	0001	22081
	Dharist		1. Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
	Physici /Medio		Sarah Jane Corley	J	June 30,	^{ay} 2004	9:45 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	c. County of Death	
			7309 Carroll Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Bryans Road J If Under 1 Year If Under 24 Hrs. 8.		Charles	nea (State or Foreign
	Funeral Director		232-70-2060 1 M 2 M F 63 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Year IG. 15, 1	940 West	ace (State or Foreign (Y) Virginia
	yland 10W		10a. State 10b. County 10c. City, Town or I	ocation		10	d. Inside City Limits
	a-fsh	tor	Maryland Charles Brya	ns Road			1 □ Yes 2 □ No
	or 28	Olre	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Count	ry?
	s 23a	a	7309 Carroll Drive	20616		USA	
^	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show he Medical Examiner must be nailified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) Ves 2 \(\text{M} \) No	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	14. Race - America Black, White, e	
2-003p	ours a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No Specify:		Specify: Whi	te
<u>ה</u>	natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Ind	ustry
717	within ene. than	duc	Elementary/Secondary (U-12) College (1-4or 5+)	emaker		Own Hor	me
	filed Hygi other	O)	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	irst, Middle, Maide		
yland		ToB	George Alford Shipp	Misshie	Marie M	iller	
Mary	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip (Code)
ر. ح	マミトラ			Carroll Drive, Brya			
<u></u>	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		IAL buriar 2 Cremation 3 Chemovaritom State	position (Name of Date smallory or other place)		_ocation - City or Tov	vn, State
	it. Pa intmer intent njury			Memorial Gdns 7-3-04	Wal	dorf, MD	
g	Depril		MO1246	22. Name and Address of Facility untt Funeral Home . O. Box 156. Waldor	e MD 30	601 0156	
Ħ			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	I OI DOM AVO, HWIGOI			Approximate
	Physician		Immediate Cause (Final disease or condition	Cardo vasular	1.01		Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	(a) and o process	1/1 /16/19	0	zago
	Examiner	L.	Sequentially list conditions, bb.				
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury				
,	execu n and ial-tra	Examiner	that initiated events c				
2/00	certificate be executed Iding physician and Ise as the burial-transit	call	d				
ŏ	rtifica ng ph		IF FEMALE:				
X D D	ath ce	ian/l	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy	1	23d. Date of delivery	y Day Year
5	or Attending Physicien: The law requires that the death certificate be executed the death. Certificate be executed bitectors. After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	Physician/Med	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			,
Ž.	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
coras,	quires an sign uld be	ed by			1 ☐ Yes 2	No 3 ☐ Proba	bly 4 Z Unknown
ວ	law re as bee 2 sho	ompleted			24a. Was an	24b. Were autops	sy findings available
	The ate has page	Com			autopsy performed? 1 ☐ Yes 2 ☑ No	death?	pletion of cause of
V 1 [2]	iclen: sertific ector,	Be (25. Was case referred to medical examiner?	26. Place of Death (Ch	heck only one)		
5	Physi this c	To	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie 27. Manner of Death		5 Residence Describe how inju-		
5	ding th. After fune	tion	27. Manner of Death 1	of 28c. Injury at 28d. Work? M 1 □ Yes 2 □ No	. Describe now inju	ry occurred	
2	Atten	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s			nd Number or Rural	Route Number,
5	tal or rs afte al Dir	O	4 Homicide Statements building, etc. (Specify)		City or Town, Stat	θ)	
	To the Hospital or Attending Physicien: The law within 24 bours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 to the funeral director, page 2 to the funeral director.	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred a	due to the cause(s at the time, date an	s) and manner as started place, and due to t	ted. he cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Da	
			18/	045365	0	7-01-	2005
2	Q 11		30. Name and address of person who completed cause of death (Item 23a) (Type		Wachingt	on MD 20	7/1/1
4	D D Sta	te	Michael G. Sidarous, MD, 11701 Livin 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	yston Ru. #101, Ft.	wasiiiiyt	טוו, ויוט בטי	7 44
	Registr		31. Date filed (Month, Day, Year) JUL 0 1 2004 32. Registrar's Signature,	Gosson			

DHMH 17 Rev 1/2001

		. For		State of N	/laryland	/ Depa	artment of H	Health and M	Mental Hy	<u>g</u> iene		
	1	- Stata Registrar				Cer	tificate of	Death		Reg. No.	104	22085
sician		1. Decedent's Name (First	, <i>Middle</i> , La	st)					2. Date of De		Vear	3. Time of Death
sician edical		RYAN CHRIST	OPHER	COPELAND					June	27 ^{ay}	2004	10:30 P M
miner	_	a. Facility Name (If not in	_					or Location of Death	1	4c. Cou	nty of Death	
		University of Social Security Number					Baltir If Under 1 Year		0.0-1-10			[/A
tor		224-49-5315 Usual Residence of Dece	1	X M 2□ F	Age (In yrs. Ia 22	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da SEPT. 4	y, Year)	9. Birthi Coul MAR	olace (State or Foreign ntry) YLAND
a	-		County		10c. City,	Town or Lo	cation				1	10d. Inside City Limits
ţ		MD QU	JEEN A	NNE'S	STEV	ENSVII	LE				i i	1 ☐ Yes 2 X No
Director		10e. Street and Number			0		10f. Zip Code			10g. Citizen o	of What Cour	ntry?
i i		1014 LOVE B	OTNT	ROAD			21666			USA		.,
Funeral	-	11. Marital Status		12. Was Deceder	t Ever in U.S	. 13. V	Vas Decedent of H	lispanic Origin? (Sp	pecify Yes or No	- 14. R	ace - Americ	
once. To Be Completed by Funeral Director		1 X Never Married 2		Armed Forces 1 Tyes 2 1			Yes, specify Cub	an, Mexican, Puerto	rican, etc.)		lack, White,	
l by		3 Widowed 4 D	ivorced	Year or Dates	:		H Tes 21A No	Specify:		Spec	cify: W.H	IITE
Completed		15. D (Specify only	ecedent's Ed highest gra	ducation de completed)		(Give .	ent's Usual Occup	during most of world	king	16b. Kind of	Business/In	dustry
ldm	-	Elementary/Secondary	(0-12)	College (1-4o	r 5+)		OO NOT use retire	d)				
ပိ		12 17. Father's Name (First, I	Middle Last			BARTI	LNDEK	18. Mother's Nam	o /Fina Middle	RESTA		
Be		DONALD COPE							ET HOLTH		airie)	
ĭ	으	19a. Informant's Name/Re		Tyne Print)		10h Mailin	a Address /Street	and Number or Rui			- Ctota 7:-	0-1-1
		DONALD COPE						NT ROAD,				
	-	20a. Method of Disposition			20b. Pla	ce of Dispos	sition (Name of		Date	20c. Location		21666 own. State
		1 ☐ Burial 2 X Cren 1 ☐ Donation 5 ☐ C			θ		natory or other plac	1	1 /000/		·	
ani di	ì	21. Signature of Funeral S		. /	CHES	22	Name and Addre	ORY 07/0		STEVEN		
a		160	NIC	11050	-	FE	LLOWS. H	ELFENBEIN CK ROAD,	CHESTER	AM FUN	ERAL H 21619	OME, P.A.
	+	23a. Part1. Enter the dise shock, or heart failur	ase, or com	plications that caus	ed the death.						21019	Approximate
ំ ជា៖		Immediate Cause (Final	e. List only	one cade on each	~1	000	. /1.	. ()	CW.	1		Interval Between Onset and Death
al		disease or condition resulting in death)	-	a Due to (or a	s a conse ue	PHU	us croc	uds o	1 ITCA	4	-	
er				•	2 22.100400							
je j	10	Sequentially list condition ,	s,	b. Swe to (or a	в а попвесна	nce of):						
amine		Cause (Disease or injury that initiated events	1	c.								
Ä		resulting in death) Last		Due to (or a	s a conseque	nce of):						
cal				_ d.								
Jed	-	IE ECMAI F								-		
an/A		IF FEMALE: 23b. Was decedent pregn		23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnancy	,			ate of delive	,
/sician/Medical Ex		in the past 12 month 1 Yes 2 No	5 /	4☐Pregnant 9☐Unknown			Other (specify)			٨	Month	Day Year
Physician/Medical	+	9 🗆 Unknown							_			
by	ľ	Part II. Other significant of	onditions o	ontributing to death	but not result	ing in the un	derlying cause giv	en in Part I.		A /		e cause of death?
									1 🗆 Y	es 2 No	3 Prob	ably 4 □Unknown
Q.									24a. Was autop		. Were autor	osy findings available
n: To Be Comple									A perfor	med?	death?	2 No
Be		25. Was case referred to examiner?	medical					26. Place of Deat	- /		1	
		1 XYes 2 No		Hospital: 1 X Inpat	ient 2 El	NOutpatient	3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	ence 6 🗆 O	ther (Specify	*1
မ												/

Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physical within 24 hours after death.

To tha Funeral Director: After this completely filled in by the funeral director.

Baltimore, Maryland 21215-0036

Medical Certification:

State

Registrar

1 Natural

Accident
3 Suicide

4 - Homicide

29a. Certifier

29b. Signat

5 Pending investigation

6 Could not be determined

At home, farm, (Specify)

street, factory, office

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 28, 2004

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

JUN 3 0 2004

			1- For Amend Item 23 Registrar	State of Marylands Sa per Dr., 683	3,0271 3,0271	ntment of F 3/04dhb tificate of	lealth and N <i>Death</i>	Mental Hygie	ene LNoD () () ()	0000
			Decedent's Name (First, Middle, Last)					2. Date of Death	7004	3. Time of Death
	Physici /Medio		Katherin	e R. DiLorenzo	0			June	Day Yeer 2004	1155 A ^M
1	Examir		4a. Fecility Name (If not institution, give s	street and number)			Location of Death		4c. County of Deeth	
			Union Hospital			Elktor			Cecil	
	Funeral Director		043-03-7727	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y SEPT 10,	'ear) 9. Birth Cou 1918 Ne	place (State or Foreign intry) W York
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation			-	10d. Inside City Limits
	Mary Firsh	ţō	Maryland Cecil	E	lkton					1 XYes 2 ☐ No
	or 28s	irec	10e. Street and Number			10f. Zip Code		10g	J. Citizen of What Cou	intry?
	23a	ral	313 Elkton Boulev	ard		21921			United St	tates
	er de	une		12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show he Madigal Examinar must be notified at	Completed by Funeral Director	1 Never Married 2 Marned 3 Nover Married 2 Marned	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐Yes 2XNo	Specify:		Specify: Tul	hite
21215-0036	2 hou	ted	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occup	ation	16	b. Kind of Business/Ir	
2	ithin 7	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. [NOT use retired	during most of work ()	ing		
2	filed w Hygier other th	Cor	12		Own	er/Operat			Restaurant	
Maryland		Be	17. Father's Name (First, Middle, Last) Costas Andrianos					e (First, Middle, Ma	iden Sumame)	
2	should be nd Mental marked c	To	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	a Address (Street a	Elene G		city or Town, State, Zi	Code)
	and 2 seath are n 27 is		Tina Scott/Daught					n, Maryla		, 0000
ore,	es 1 a of Hea litem r othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re	20b PI	ace of Dispos	sition /Name of		Date 20	č. Location - City or T	own, Stete
Ĕ.	Pages ment of I ant: If ite ury or o		'4 □Donation 5 □ Other (Specify)	emoval from State Lmma Ceme	aculate etery	e Concept	ion 2004		nerry Hill	Marvland
Baltimore,	permit. Pages 1 an Department of Heat Important: If item 2 any injury or other once.		21. Signature of Funeral Service License	المن المان الم	Hi	Name and Address Home	for Fune	rals, P.A		-
4			23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not wite	er the mode of dying	g, such as cardiac	or respiratory arrest	· Mary 1	Approximate Interval Between
	Physician /Medical	i	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		A JYMIN	cute Pulm	onary Ede	ma	Onset and Death
Åι	Examiner				erice or,	Ac	cute Rena	l Failure		
	D #	Iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to for as a consequ	anca of).					
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					·		
68760,	icate be executed physician and s the burial-transit	aiE		Due to (or as a consequ	erice or):					
687		edicai	_ d							
Вох	anding use a		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar					23d. Date of delive	ery
	it the death certific by the attending p tached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1☐Live birth 2☐Fetel 4☐Pregnant at time of de 9☐Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
<u>о</u>	d by the	Phy	9 Unknown							
Division of Vital Records,	The law requires that the death certit te has been signed by the attending rage 2 should be detached for use a	by	Part II. Other significant conditions con	Line Mill	lting in the un	derlying cause give	on in Part I.	23e. Did tobac	co use contribute to the 2 No 3 Prot	he cause of death? pably 4 DUnknown
000	e law re has bee	Completed						24a. Was an	24b. Were auto	psy findings available
Ĩ		Com						autopsy performed	d?_ death?	mpletion of cause of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					(Check only one)		
o	Physic this cral dir	7	1 Yes 2 No	1	R/Outpatient 28b. Time of		4 Li Nursing Ho		e 6 ☐Other (Specif	y)
0	ding F h. After funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe how i	injury occurred	
VISI	Atten r deal ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	ne, farm, stre			28f. Location (Stree	t and Number or Rura	I Route Number,
ā	tal or s afte al Dir	Certification:	4 Homicide	building, etc. (Specify)				City or Town, S	itate)	
	To the Hospital or Attending Physician: which 24 hours after deals as the feathing to the funeral Director. After this certified completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying Physical Continuous 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or invi	occurred at the timestigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due lo	tated. the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			29c. License			Date signed (Month,	Day, Year)
	11		> MM MO			V009	56698	Ji	INE 15, 2	004
_	4		30. Name and address of person who cor	0011 CM	LOVER	rint) ING AVB	. 2-014	WILLIN	GTON, DEV	AWAKE 19806
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signar		acker				

				1- For Amend Item #5 State of Maryland./ Depart 1- Registrar Amend Item 5 per informant Certification	iment as Health and Mer ficate of Death G837 1	ntal Hygi as 1-5-04	ene as	22097
		Physici	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month	Day Year	3. Time of Death
		/Medio	cal	Hampton Neil Dove, Sr.		une 27,	2004	02:20 Рм
		Examir	ner	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	b. City, Town, or Location of Death Clinton		4c. County of Death	
		Funeral		5. Segical Segurity Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day,)		oplace (State or Foreign untry)
		Director		720-01-4391 XX 84 Yrs.	Nontris Days Hours Min.	Dec 20	, 1919 Was	shington DC
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	tion			10d. Inside City Limits
		Mary a-f sh	tor	Maryland Prince George's Forrest	ville Forestvi	lle		1 □ Yes 2 □ No
		or 284	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Co	
		s 23a	rall	7415 Marlboro Pike	20747		nited Stat	
7	"	ter de r Item inerr	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1. ₩as Decedent Ever in U.S. Armed Forces? 1. ₩as Decedent Ever in U.S. Armed Forces?	s Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Rica (Specify Cuban, Mexican, Puerto Rica)	y Yes or No- an, etc.)	14. Race - Amer Black, White	
à	5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Alcel Examinate must be rollined at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Il YAs, Give Year or Dates:	Yes XX No Specify:		Specify: W	Mhite
20	5-0	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-f show addeal Examinar must be notified at	Completed	15. Decedent's Education 16a. Deceden (Specify only highest grade completed) (Give kin	nt's Usual Occupation Id of work done during most of working NOT use retired)	16	6b. Kind of Business/I	ndustry
2:20	2121	within ene. than "	Jumo	Elementary/Secondary (0-12) College (1-4or 5+)	ldiers Home Driver		Federal Go	vernment
0		filed I Hygi other /ent, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (F			Vermiene
(9)	lar	should be nd Mental marked o	To B	Raynor Earl Dove	Eva Sı	ıit		
	Maryland	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or tiems 23a or 28a-f show any injury or other traumatic event. It a Medical Examination ust be notified at ance.		19a. Informant's Name/Relationship (Type, Print) Neil Dove (SON) 4101	Address (Street and Number or Rural Ro Forestville Road,	oute Number, (Forres	City or Town, State, Z tville, Ma	ip Code) ry1and20747
127/04		s 1 an f Heal item 2 other		20a. Method of Disposition 20b. Place of Disposition			0c. Location - City or 1	
27	altimore,	Page nent o ant: If ury or		1 Diogram 2 Community 3 Endinoval from State	Cemetery July 1. 2	2004	Suitland	Maryland
3	Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee 22. N			Home, Inc	
0		<u>205</u>		Fell R. Fattee MOII 90 Ale	exandira Ferry Road	l, Clin	ton, Maryl	and 20735
		D		23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line. Immediate Cause (Final	me mode or dying, such as cardiac or re	spiratory arres	51,	Approximate Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):				ZWEEKS
		Examiner		Sequentially list conditions b. INTRACLAWIAL	BLEED			ZWEEKS
		ed	Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	LOTIC CARDI	N 1181	(VA)	CIC. Anc
	,	ate be executed hysician and the burial-transit	Exan	that initiated events resulting in death) Last C. Due to (or as a consequence of):	rein grun	W130	NICEME	4 CAPLL
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	9	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:				
	Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	topic pregnancy		23d. Date of deliver Month	very Day Year
	0	that the de od by the detached	hysic	1 Yes 2 No 9 Unknown 9 Unknown	trier (specify)			
2	o,	The law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the under	orlying cause given in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ton	ords,	w require been si should b				1 🗆 Yes	2 ⊠ No 3 □ Pro	bably 4 Unknown
5	3ec	The law cate has b page 2 st	Completed			24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
4	al	(0	O C	25. Was case referred to medical		1 ☐ Yes 2	No 1 ☐ Yes	2□ No
7	<u>S</u>	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (C		ce 6 Other (Spec	ifu)
. ~	n of	ding Physician: h. After this certific funeral director,	T :uc	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			injury occurred	.,,,
14	Sio	Attanding It death. ector: After by the fune	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
00	Division	al or At s after of It Direct of in by	Certification	determined determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office 28f.	City or Town,	et and Number or Rui State)	rai Route Number,
		To the Hospital or Attanowith n 24 hours after death To the Funeral Director:	Medical (29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death or control on the basis of examination and/or invessed and manner stated.	ccurred at the time, date and place, and tigation, in my opinion, death occurred a	due to the cau it the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
_		To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number	_	d. Date signed (Month	
				1/10	D-18545	7	UNE 2	2, 5004
	1	R INEL		3. Name and address of person who completed cause of death (Item 23a) (Type, Pri	D-18545 NE CENTEL W	ALAGO	F AAd	20402
		Sta	ite	31 Date filed (Month, Day, Year) 1 32. Hellistrar's Signature	Y		- I WICH.	ب سامان
		Registr		JUL 0 2 2004 Jane & Some				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3: Time of Dealth 2. Date of Death 1. Decedent's Name (First, Middle, Last) . 2004 **Physician** June 26, 8:40 P M Doris Jean Deihl /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Gambrills 2510 Davidsonville Rd. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2XXF Days Hours Months Yrs. 56 8-19-1947 093-38-8225 Pennsylvania Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 XNo Directo Gambrills Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2510 Davidsonville Rd. 21054 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 XNo If Yes, Give Year or Dates: t Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bookkeeper Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Turkovich John Democko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Deihl/ Husband 2510 Davidsonville Rd., Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) 6-30-04 Edgewater, MD Kalas Crematory 21. Signatur Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) NON SMALL 115 Due to (or as a consequence of)

Physician /Medical **Examiner**

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Funeral

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or 28e-f ehow

r than "naturel", or Iteme 23a or 28e-f ehov the Medical Examenar must be notified at

al Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 ie marked other eny injury or other treumatic event, I

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence of)

CELL	LUNG	CANCER	Onset and Death

Examine Physician/Medical IF FEMALE: þ Completed 25. Was case referred to medical Be P 27. Manner of Death Certification:

Medicai

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown

autopsy 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

26. Place of Death (Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1 Yes 2 No.

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Momicide

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) MD 8926 WOODYARD

Hospital:

ROAD #201 CLINTON MM 20735

Registrar

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 ☐ Could not be



		1 - For State Registrar	State of M	arylan		artment of i		nd Mental F	lygiene Reg. No.	200	1 000	0.00
Physici /Medi		Decedent's Name (First, Middle, L. Charlotte	Lee		Dickel			2. Date of Month Jul 7		1 Yes	3. Time o	#Death M
Examir		4a. Fecility Name (If not institution, gi 1815 Frederick S	Street			4b. City, Town, Cumbe	erland	Death	4c.	county of D llegan		
Funeral Director	-		Sex 1 □ M 2 □ X	e (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of (Month, Jan	Birth Day, Ye <i>ar)</i> 13, 19	29 9.1	Birthplace (State Country)	or Foreign
Maryland -f ehow	tor	10a. State MD Allega	any	10c. Cit	y, Town or Lo Cum	cation berland					10d. fnside C	ity Limits
3a or 28e	i Director	10e. Street and Number 1815 Frederick S	Street	l		10f. Zip Code	21502		10g. Citiz	ten of What	Country?	
5-0036 72 hours after death with the Maryland naturel; or Items 23a or 28e-f ehow dical Evantiner mant te notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 V If Yes, Give Year or Dates:		1	Was Decedent of If Yes, specify Cub		n? (Specify Yes or Puerto Rican, etc.)		4. Race - A Black, W	merican Indian,	
2121 ad within giene.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of	of working		eway N	ss/Industry // Arket	
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and 2 shealth and 2 shealth and 27 le m		19a. Informant's Name/Relationship Robert Dickel	Type, Print) husb			CONTRACTOR OF THE PARTY OF	and Number ck Stre	or Rural Route Nun et Cur	nber, City or nberla	Town, State	a, <i>Zip Code)</i> MD 2150)2
Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or othe ance.		20a. Method of Disposition 1	fy)	l a	emetery, cien stlawn N	sition (Name of patory or other pla lemorial Ga	ardens	Date 7/10/20	D4 La	vale	or Town, State	MD
Dermi Depa tmpo any ii		21. Signature of Funeral Service Lice 23a. Pert1. Enter the disease, or con	4. DCO	MA	MI	108 Vir	ginia Av	al Home, PA enue: Cumb	erland.	MD 21	502	
/Medical Examiner be executed be executed by it is private and the private transit the private ransit can be executed by the private ransit can be	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a consequ	uence of):	-cell	Lyny	hont		۵-	Onset and I	P-S
.O. BOX 6 the death certifi y the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)	1		2:	3d. Date of d Month		/ear
Cords, P	by	Part II. Other significant conditions	contributing to death bi	ut not resu	ilting in the un	derlying cause giv	en in Part I.		l tobacco us		to the cause of d	
	Completed							24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to death?	autopsy findings a completion of ca s 2 No	available ause of
	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatient	3 DOA Oth	0.0	Death (Check only ng Home 5 12 He		☐Other (Sp	pecify)	
DIVISION Of VITA or Attending Prysiclen: after death. Director: Atter this certification by the funeral director.		27. Manne eath 1 Patural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be		Year)	28b. Time of Injury			28d. Describe				
Dia affe	O	4 Homicide determined	building, etc	. (Specify)			City or T	own, State)		Rural Route Numb	oer,
To the Hospite within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examinat	Medge, death ion and/or inv	occurred at the tire estigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time	e cause(s) a , date and p	nd manner a lace, and du	as stated. ue to the cause(s)	
To t To t com		29b. Signature and title of confrier	gorev	M)	29c. Licens D221			29d. Date	signed (Mor	onth, Day, Year) P, 200	24
		30. Name and address of person who Gary Wagoner, M.	/			rint) Drive; C	umber1a	and, MD	21502	/	,	
Sta Registr	re.	31. Date filed (Month, Day, Year)	32. Rěgistra	r's Signat		24	1. 0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#20c, perFH, FCHD, SL Certificate of Death 6/29/04 Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 24 2004 Phyllis Virginia Frye 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Flen BURNIE ANNE ARUNDEL ARUNDEL Hospita NORTH If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct. 29, 5. Social Security Number Days 1 □ M 2 🛛 F 73 Yrs 579-48-0851 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 322 Piney Point Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Machine Operator Plastic Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Roy Norman Frye Pearl Pauline Shackelford 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Brackett - Niece 1 Cornell Estates - Kearneysville, WV 25430 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Martinsburg, WV Pleasant View Memory Gar. 6/28/2004 22. Name and Address of Facility Eackles-Spencer Funeral Home 21. Signature of Funeral Service Licensee M970 Harpers Ferry, WV 25425 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Mogth Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellisas 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Physician /Medical **Examiner**

permit. Page Department o Important: If eny injury or once.

Physician

/Medical

Examiner

Funeral

Director

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Items 23a

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"natural",

al Hygiene.

Pages 1 and 2 should be fil ment of Health and Mental H ant: If tem 27 is marked otl

Director

Be Completed by Funeral

MD

or other traumatic event, the Medical Examiner must be notified at

the Maryland

anding physician and use as the burial-transit page

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

To the Hospital

death.

after death Director:

Completed by Physician/Medical Examiner Be ۵ Medical Certification: in by to use within 24 hours are To the Funeral Dir

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown 25. Was case referred to medical examiner? Hospital: 1 Anpatient

28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 Could not be determined

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

24a. Was an autopsy

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sector.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State

1 Tes

27. Magner of D. ath 1 Natural

1 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

31. Date filed (Month, Day, Year)

32. Registrar's Si 9 2004

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient

28b. Time of

Injury

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

yan Gree 1-04385	ene	Plea	ise Type or Pr	rint in Blac	k Inc	delible Ink.	Ensure A	All Copies	s Are	Legible.		
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Examin	ęŕ	4a. Facility Name (If not institution					r Location of Deat	h		County of Dea		
		Peninsula Regi		AL CENTER Age (In yrs. last bi		Salisbu	If Under 24 Hrs	8. Date of B		icomico	thplace (State or	r Foreign
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s 23s	rai		12. Was Decede	at Ever in III C	12.14	Vas Decedent of H		Posity Voc or N		14. Race - Am	occan Indian	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23a or 28a-f show with injury or other treumatic event, Item Medical Eracificat Charling an Once.	by Fune	11. Marital Status Never Married 2 Mar Widowed 4 Divorce	ried 1 Yes of	es? ₹No	lf lf	Yes, specify Cuba	Specify:	to Rican, etc.)		Black, Whi	ite, etc.	
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d 2 shouth and N		19a. Informant's Name/Relation Wendy D. Sauer				g Address (Street CCumbee			_			
Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition	3 Removal from Sta	20b. Place o	of Dispos	sition (Name of natory or other place Cemetery	(a)	Date	20c. Lo	ocation - City o		WV
permit. Pa Departmer Importent eny injury		* 4 □ Donation 5 □ Other (3				Name and Addre	ii				7111907	
90 5 9		Darbon) Soul) M00522	9	5 Union	St., Ber	keley S	oring	s, WV	25411	
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Pnysician /Medical Examiner		disease or condition resulting in death)		as a consequence		راقع ا						
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To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏Fetal death t at time of death		Ectopic pregnancy Other (specify)	1			23d. Date of de Month		ear/
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after de Directo	Certification:	3 Suicide 6 Could 4 Homicide deter	mined 200. Place of building	Injury - At home, f , etc. (Specify)		eet, factory, office		City or To	wn, State)	Rural Route Numb	
Hospita 4 hours Funerel ety fillec	edical C	(Check only 2 Medice	ing Physician: To the be I Examiner: On the basi	est of my knowledg	e, death			e, and due to the	a cause(s)	and manner a	s stated.	
thin 2 the 1 the 1 mplet	Med	one) 29b. Signature and title of certific	and manner	r stated.		29c. Licens	e number		29d. Dai	te signed (Mon	th, Day, Year)	
7 × 5		Mounte	Donellye	6		001				y 5, 20		
A		30. Name and address of person	who completed cause	of death (Item 23a)	(Type, I	Print)						

State Registrar 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Joyce Brown Gladhill June 28 2004 4:27p M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Holy Cross Hospital 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F 1929 Virginia 228-30-3298 74 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28a-f show Exercises must be notified at 1 ☐ Yes 2 No Maryland Damascus Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11000 Bethesda Church Road 20872 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite sther traumatic event, the Medical Experiment. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify ģ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie Burrows 2 Edgar Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permil, Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. Delaney B. Gladhill/ Son 11504 Windsor Road, Ijamsville, Maryland 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) June 30, 04 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia Megropolitan Crematorium Inc. 22 Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 20401 Ridge Road, Damascus, Maryland 20872 21. Signature of Emeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Carcinoma of the Peritoneum Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No the 9□ Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🖾 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 24 hours after deatl e Funaral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD060335 June 29, 2004 Partsan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Banner M.D. 18111 Prince Philip Drive, Olney, Maryland JUL U I 32. Registrar's Signature 31. Date filed (Month, Day, State 2004 racks Registrar

Thelma Hunt 04-4228 AKG

422	8		For	State of	Maryland				Mental Hyg	iene	
			1 - State Registrar			Cer	tificate of	Death	-	g. No. UU	<u> </u>
П	Physici	an	1. Decedent's Name (First, Middle Thelma Louise						2. Date of Death Month	Day Yo	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution		oer)		4b. City, Town, o	r Location of Death	June 28	3, 2004 4c. County of	8:15 A [™]
	Exami	EI	1007 Forest Hi		·		Annap			Anne Ar	
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		216-22-3253 Usual Residence of Decedent	I I I Z	7.7	Yrs.			June 24		Maryland Maryland
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Linust be notified at	ctor	Maryland Anne	Arundel	Anna	apolis					1 es 2 No
	or 28	Dire	10e. Street and Number			• 11	10f. Zip Code		10	g. Citizen of Wha	at Country?
	s 23a	erai	1007 Forest Hil	12. Was Decede	ant Francis II C	2 42 1	21403	i i - O - i - i - 2 (0-		United S	tates American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, The Medical Exertifier must be naillied at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3	ried Armed Force 1 ☐ Yes 2	es? No	l	was Decedent of H f Yes, specify Cuba I ☐ Yes 2 P No	ispanic Origin? (Spanic Origin? (Spanic Origin) (Specify:	Rican, etc.)	Black, \	White, etc. white
2-0	72 ho	Completed	15. Deceden	t's Education st grade completed)		16a. Decec	lent's Usual Occup	ation	kina	16b. Kind of Busin	ess/Industry
2	within ene. than "	mpie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	00 NOT use retired memaker	during most of world)	g	own h	ome
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Maryland	3.2 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic event, the Mes	To Be	Joseph Stevens						ta Srnec		
ary	shou and M s mar		19a. Informant's Name/Relations					and Number or Ru	ral Route Number,	City or Town, Sta	
₹,	and 2 ealth m 27 i		Laura Kramer/ o	laughter				and the same of th	ın e Edg e w		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		Ce	metery, cren	sition (Name of natory or other place en Cemeto	la l	2, 2004	Glen B	y or Town, State urnie, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	t Roman	dú					-	eral Home, Inc is, MD 21401
г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	ised the death. th line.			-			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ Smake	inhale	ution	aul	Thenua	Q The	ny	Onset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):					
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с							
90,	oe execian a	EX	resulting in death) Last	Due to (or	as a consequ	ence of):					
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	law requires that the death certif as been signed by the attending 2 should be detached for use a	by	Part II. Other significant condition	ns contributing to deat	th but not resul	iting in the ur	derlying cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
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of	Physician: this certific ral director,	5	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inp		R/Outpatient		4 Nursing no			Specify) At scene
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Ö	s afte	Cert	4 Homelde	building,	, etc. (Specify)	sme			Amabolis		Forest Itill And.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifyin (Check only one)	ng Physicien: To the be Exeminer: On the basi and manner	is of examination	viedge, death on and/or inv	occurred at the timestigation, in my o	e date and place.	and due to the car	ise(s) and manne	r as stated
	Tot Tot com	Σ	29b. Signature and title of certifier	1	10		29c. License		29	d. Date signed (M	
7			X V V	the 1	"		0.C.	M.E.		June 29	, 2004
			30. Name and address of person	OGAN)		111 Pen	n Street,	Baltimo	ore, Mary	vland 21201
	Sta Registr		31. Date filed (Month, Day, Year)	4 4	erar's Signatu		had.				

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	ith the Marylar or 28a-f show	7	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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	with sa or						10f. Zip Code		}	10g. Cit	izen of What C	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tems 23s or 28s-f show ont. The Medical Evaluinet for malified an	Funeral	2521 Maytime I	12. Was Decedent	Ever in U.	S. 13. V	21054 Vas Decedent of H		cify Yes or No-		USA 14. Race - Am	
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HAZEN CARL D Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 [☐Removal from State	CE	metery, crem	sition (Name of atory or other place	e)	ate		cation - City or	
ij.	permit. Page Department Important: If any injury o		* 4 ☐ Donation 5 ☐ Other (Speci	ify)	Mer		ematory		04	Bal	timore	, Ma.
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Lice	On- Man	alker	22.	Name and Address Wm. Ree	s of Facility se & Son t St. An	s Mort	ţua:	ry, P.	Α
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			30. Name and address of person who		leath (Item :	- 23a) (Type, P	rint)				()	1
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		-	1 - For State Registrar		epartment of Health and N Certificate of Death		ene . No 2 0 0 4	22095
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) DAVID	HOLMES		2. Date of Death Month June	Day Year 26 290	3. Time of Death 4 6:00 A M
	Examin	er	4a. Fecility Name (If not institution, give str The Respite Home or	South Haven	4b. City, Town, or Location of Death Annapolis Jav. If Under 1 Year If Under 24 Hrs.			un del
	Funeral Director		224-32-3334	7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Y August 1	ear) Cou	place (State or Foreign unity) Washington
	the Maryland 28a-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arun 10e. Street and Number	nde1 10c. City, Town on the Annapol		10g	, Citizen of What Co	10d. Inside City Limits 1 ∰Yes 2 ☐ No untry?
10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evarith writinal be notified at ance.	Funeral Director	4 Chesapeake Landir 11. Marital Status 1 Never Married 20 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ■Yes 2 □ No	21403 13. Was Decedent of Hispanic Origin? (Signature of Specify Cuban, Mexican, Puerto	pecify Yes or No-	Jnited Sta 14. Race - Amer Black, White	rican Indian, e, etc.
21215-0036	in 72 hours al	Completed by	3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade)	completed) (1 ☐ Yes 2 ☑No Specify: Pecedent's Usual Occupation Give kind of work done during most of wor itie. DO NOT use retired)		Specify: whi	
1d 212	e filed with al Hygiene. other than vent, Ital	Be Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4	Officer 18. Mother's Nam	ne (First, Middle, Ma	J.S. Navy	
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Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Jo 147 Duke of Glouce	hn M. Tay	lor Funer	al Home, Inc
8760,	Physician /Medical Examiner and the prize transit	al Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fair learny large transplant immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of trul	15): ,(()Q	or respiratory arres		Approximate Interval Between Onset and Death
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_			30. Name and address of person who cor Part U. Green field 31. Date filed (Month, Day, Year)	mplet of cause of death (Item 23a) (1	l Solomn's Isl	el; Ba	enjacks)	2/40/
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Smart o			

			1 - For State Registrar	State of Marylar		artment of latificate of			ene	22000
	Physic /Medi	cal		seph	Higgin				Day Year 2004	3: Time of Death 0 12:00 P.M
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	h with the 23a or 28a at be noti	Funeral Director	10e. Street and Number 13305 Vanessa Ave		10	10f. Zip Code	0720		g. Citizen of What Co	untry?
980	within 72 hours after deeth with the Maryland ane. than "netural", or items 23a or 28a-f show 's Modeul Exceptement be notified at	by	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates: 1942	li li	Vas Decedent of it Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 4	(Give life. L	OO NOT use retire	during most of wor	king	Sb. Kind of Business/Oepartment Agricult	Of
yland	should be filed ind Mental Hygi marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Patrick	Higgins			Mary		chosker	
	is 1 and 2 should of Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty, Irene Higgins/ Wif	e	13305	Vanessa		Bowie, Ma		0720
Baltimore,	Page ento nt: If		20a. Method of Disposition 1	Removal from State Ar1	emetery, crem ington	sition (Name of patory or other pla Nationa	1 7/20	/2004 Ar	lington,	Virginia
Ба	permit. I Departm Importe any inju		21. Signature of Funaval Service 1 n. 22. Signature of Funaval Service 2 n. 23a. Part 1. Enter the disease, or compli	5	160	000 Anna	polis Roa	d, Bowie,	vans Fune Maryland	
8/00,	Cate be executed /Medical physician and the burial-transit	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Lance of):	Cana	homy ut Di	sear	thy	Interval Batween Onset and Death Secure
O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3⊡	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	rery Day Year
cords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute to	
ď	The lay ate has page 2	e Completed	25. Was case referred to medical				OC Plans of Post	24a. Was an autopsy performer 1 Yes 2*5	prior to co	opsy findings available ompletion of cause of
5	ding Phy n. After this funeral d	atlon: To B	examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 ursing Ho		e 6 Other (Speci injury occurred	(fy)
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or Town, S		
	the Hosp nin 24 hor the Fune npletely fi	Medical	one)	sicien: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death ion and/or inve	estigation, in my o	pinion, death occur	red at the time, date	and place, and due t	o the cause(s)
	To To	-	29b. Signature and title of certifier	n ou one			2010		Date signed (Month,	Day, Year)
	Sta	to	30. Name and address of person who con Rakesh Arora, M.D. 31. Date filed (Month, Day, Year)		nt Fox	•	uite 222,	Bowie, M	aryland 2	20715
	Sta Registr		JUN 28 20		K A	made)				

		ı	For	State of Ma	aryland /				nd Me	ental Hy	/giene	9		
			State Registrar			Cei	tificate of	Death		2. Date of D	Reg. No	200	1	3. Time of Death
	Physicia		Decedent's Name (First, Middle, Las	11-						Month	Da	1y	Year	
	/Medic	al .	Thomas	1419	95				-	JUNE_		2004		2:30 P M
1	Examin	_	4a. Facility Name (If not institution, give				4b. City, Town,		t Death				ARUN	חביו
			ANNE ARUNDEL MEDI			histografi	ANNAPOL If Under 1 Year		24 Hrs.	B. Date of B	irth	-		Iace (State or Foreign
н	Funeral		5. Social Security Number 6. S	ex ⊋M 2□F 7. Ag	e (in yrs. last i 91		Months Days		Min.	JULY 1	ay, Year	112	Cour	INGTON D.C.
	Director	-	215 44 8281 Usual Residence of Decedent	Λ						30111	.,,1,	/12	WIIDII	INOTON D.C.
	tand tand		10a. State 10b. County		10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
	Marylan f ehow	ō	MARYLAND ANNE ARU	NDEL	EDGEW	ATER								1 ☐ Yes 2 No
	ith the M or 28a-f	Je C	10e. Street and Number		J		10f. Zip Code				10g. Ci	itizen of V	Vhat Cour	ntry?
	th with 23a or	<u> </u>	611 DELMAR ROAD				21037				UNI	CED S	STATE	S
	72 hours after death with the Maryland natural; or tleme 23a or 28a-f ehow lical Examinational be multified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of	Hispanic Orig	in? (Spec	ify Yes or N	0-		e - Americ	ean Indian, etc.
9	after dea or Iteme	Ī	1 Never Married 2 Married	tXXes 2□	No		1 □ Yes 2X No			,,			WHI	
03	ral', c	l by	3 Nidowed 4 ☐ Divorced	Year or Dates:	W.W.I	I								
5-0036	72 hours "natural",	Completed	15. Decedent's Ed (Specify only highest gra		16	Sa. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	ipation during most	of workin	g	16b. F	Kind of Bu	isiness/In	dustry
2121	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		VISOR	90)			II (ישת ב	т оғ	AGRICULTUR
2	filed withi Hygiene. other then		10 17. Father's Name (First, Middle, Last)	0	3	OFEN	VISOR	18. Mothe	r's Name	(First, Middl				КОКТООПТОК
ınd	ould be fi Mental H arked otl atic ever	Be	THOMAS SPENCER HI							ARET (
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23e or 28e-f ehov other traumatic event, the Madical Examinational be multipled at	⁶	19a. Informant's Name/Relationship (1	Oh Maili	ng Address (Stree	1					State, Zip	(Code)
Ma	12 sho h and 7 is mu traum									NICSV				
	1 and Health tem 27 other tr		JAMES C. HIGGS (20a. Method of Disposition	SON)	20h Place	of Dispo	BRUCE R			IATODA:	-			own, State
ō	n 0		1 ☐ Burial 2 🛣 Cremation 3 🗆				matory or other pla MATORY		5-21-	04	EDGI	₹WAT'F	ER,MD	_
Ë	trnen trnen trant:		*4 □ Donation 5 □ Other (Specifical September 21. Sign was of Funeral September Light		KALAC						_			
Baltimore,	permit. Pages 1 are Department of Hea Important: If item any injury or othe once.		21. Sign that of Funeral Septice Light	1500			2. Name and Add							
100	40240		23a. Part1. Enter the disease, or com	plications that cause	the death C		73 SOLON					LWAIL	K,MD	. 21037 Approximate
J			shock, or heart failure. List only	one cause on each li	ne.		12:201							Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a	10/01	3	HIT	6/2	4	sea-	6		_	39 -3
*	/Medical Examiner			Due to (or as	a consequenc	ce of):								
		<u></u>	Sequentially list conditions,	b. Due to (or as	a consequent	ea ory:							-	
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or as	a consequen	ce of):	· · · · · · · · · · · · · · · · · · ·							
68760,	re be exysician	cai E		4										
387	phys phys s the	왕		u										
×	de th certificate e attending phys ed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			70					23d. Da	te of delive	ery
Вох	atter I for u	ciar	in the past 12 months?	1□Live birth 4□Pregnant a			⊒Ectopic pregnan ⊒ Other (specify)	cy				Мо	nth	Day Year
0	by the	ysi	9 Unknown	9□ Unknown										
<u>α</u>	de de	by Pi	Part II. Other significant conditions	contributing to death t	out not resultin	g in the u	inderlying cause g	iven in Part I.		23e. Dio	tobacco	use cont	ribute to t	he cause of death?
ds.	uires sign									1 🗆	Yes 2	2 🗆 No	3 ☐ Prot	pably 4 @Unknown
Records,	w require si been si should l	Completed								24a. Wa		24b.	Were auto	psy findings available mpletion of cause of
Re	The lav	m.								per	opsy formed? 2 ₽N		death? 1 □ Yes	
Vital		Ö	25. Was case referred to medical			/		26. Place	of Death	(Check only				
Ξ	Physician: r this certific ral director,	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 R	/Outpatie	nt 3 DOA	the man		ne 5□Re		6 □Oth	er (Specii	(y)
o	Phy ar this aral d	H- 1	27. Manner of Death	28a. Date of Inj	ury 28	b. Time o				8d. Describe				
on	ding F th.: Alter	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y / 66//	Injury	M 1	Yes 2□	No					
Division	Attending it death. ector: Alter by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	288 Place of It	iury · At home tc. (Specify)	, farm, si	reet, factory, office	9	2		(Street a		er or Rura	al Route Number,
Ö	al or afte I Dire	Sert	4 Homicide	bulloing, e	ic. (Specify)									
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying P	hysician: To the besi	of my knowle	dge, dea	th occurred at the	time, date an	d place, a	nd due to th	e cause(s) and ma	anner as s	tated.
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	tated.	and/or if			ui occurre	o at uto utili				
	To the To the To the Comp	Σ	29b. Signature and title of curtified	, 114			29c. Lice	nse number				_		Day, Year)
			> N WWW ING				D	101	7		2	ne	18	4005,
-			30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type	Print) Mat	thew	Malt	a. M	D.			
			132 Holiday	Ct. SUF	te 201	A	Print) Mat	MIZ	2	7.0				
		ate	31. Date filed (Month, Day, Year)	2004 32. Regist	rar's Signature	8	And a							
	Regist	rar	JUN 23	2004	me l	r A								

Physician	'n	For Unpend Item State Registrar 1. Decedent's Name (First, Middle, L ANTHONY W. HAY					2. Date of Death Month JULY 1,	Day Year	3. Time of Death 11:58 AM
/Medical Examiner		ta. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or L WESTM	ocation of Death		4c. County of Death	OLL CO
uneral rector		5. Social Security Number 6. 218-84-8051	Sex 7. A 1	ge (In yrs. last birth 32 Y	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3/6/1972	Year) 9. Birtl	hplace (State or Foreig untry) Y LAND
28a-f show		Usual Residence of Decedent	L CO.	10c. City, Town	or Location MINSTER				10d. Inside City Limit
	Direct	10e. Street and Number 1407 PLEASANT	VALLEY ROA	.D	10f. Zip Code 21158		10	Og. Citizen of What Co	untry?
0 10 10	by Funera	11. Marital Status 1 ↑ Never Married 2 Married 3 ─ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	? No	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
than "natural", the Medical Ex-	Be completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		-	Decedent's Usual Occupati Give kind of work done du life. DO NOT use retired) CARPENTER	ion ring most of work		16b. Kind of Business/ RESID	Industry DENTIAL
	To Be	17. Father's Name (First, Middle, La MARVIN E. HAYE		,		CECE	e (First, мідаю, х ELIA LOCK	KERY	
27 is m r traum		19a. Informant's Name/Relationship CECELIA ANDERSON/MO		10	Mailing Address (Street ar D8 FRANKLIN AVE	., SYKESVI	LLE, MD 21	784	
Important: If item any injury or otha once.		20a. Method of Disposition 1 □ Burial 2 ☒ X remation 3 • 4 □ Donation 5 □ Other (Spe	cify)	cemetery	Disposition (Name of crematory or other place) JRG CREMATORY	JULY 1	.0, 2004	20c. Location - City or SMITHSBURG	, MD
any in		21. Signature of Funeral Service Lie	Blown	ر	22. Name and Address BROWN FUNERAL	HOME, P.C	BOX 821 RTINSBURG;	327 W KING WV 25402	ST.,
sician ledical aminer		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Narcot	line.	ot enter the mode of dying, ication and (f):			est,	Approximate Interval Between
edical aminer transit	ical Exam	shock, or heart failure. List or Immediate Cause (Final disease or condition	a Narcot Due to (or a b Due to (or a	ic Intoxi	ication and (est,	Approximate Interval Between
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			Registrar 1. Decedent's Name (First, Middle	a, Last)		erinicale or	Dealli	Reg. 2. Date of Death	No:	3: Time of Death
	Physic /Medi		VIOLA GRACE H	OLLINGSMORTH					Day Year 200	r
	Exami		4a. Facility Name (If not institution			4b. City, Town, o	or Location of Dea		4c. County of De	
			416 JOSEPH BO			QUEENS			QUEEN AI	NNE'S
	Funeral Director		5. Social Security Number 218-20-5745	1 □ M 2 1 ▼ E	(In yrs. last birthd	Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Ye	ar) (irthplece (State or Foreign Country)
4.8			Usual Residence of Decedent	8	1			JUNE 21,	191/ M	ARYLAND
	show	L	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	8e-f s	Director		ANNE 'S	QUEENS					1 Yes 2X No
	with the sor 2	Dire	10e. Street and Number	m nia noin		10f. Zip Code		10g.	Citizen of What (Country?
	ns 23	Funeral	416 JOSEPH BO	12. Was Decedent E	ver in U.S. 1	21658 3. Was Decedent of H		Specify Yes or No-	USA 14 Bace - An	nerican Indian.
21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f show digal Examinating Index profified at	þ	1 ☐ Never Married 2 ☐ Marr 3 📆 Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cuba 1 ☐ Yes ※ No	an, Mexican, Puer Specify:	to Rican, etc.)	Black, Wh	
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12	withir ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5-	-)	s. DO NOT use retired LERK-INCON		TVTSTON ST	ATE OF N	MADVI AND
9	filed Hygi other	Be Co	17. Father's Name (First, Middle,	<u> </u>		DDIKK INOO		me (First, Middle, Maid		TAKILAND
<u> a</u>	Venta Venta rrked rrked	ToB	ZEDIC EDGE				AMANDA	PARKER		
, Maryland	and 2 sho ealth and f n 27 is me		19a. Informant's Name/Relations JOAN V. POET /		416	JOSEPH BO	and Number or R	DAD, QUEENS	ty or Town, State,	Zip Code) D 21658
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other treumatic svent, It a Medical Examinating La notified at ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	pecify)	cemetery, c	sposition (Name of trematory or other place IN MEMORIAI			EASTON,	
Ba	Depar Depar Impor any in		21. Signature of Femeral Service	fleth.	- 4	08 S. LIBE	ERTY ST.,	NEWNAM FU	NERAL HO	OME, P.A. 21617
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to only one cause on each line	the death. Do not	enter the mode of dyin	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. / O	rvingor	is di	derre			Onset and Death
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188	Ka bak	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
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Вох	The law requires that the death certifications ten has been signed by the attending to be 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	′		23d. Date of de Month	elivery Day Year
о. О	res that the de signed by the a be detached f	hysi	9 Unknown	9□ Unknown						
S,	es tha gned I	ру Р	Part II. Dther significant condition	ns contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
Record	w require been sig		nimberes					1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
ec .	law r as be a 2 sh	Completed	ASCUD					24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u> </u>	sician: The law certificate has l irector, page 2 s		Atheroso	urosis - (erchil			performed	death?	s 2 No
<u> </u>	Physician: this certificatal director, p	Be (25. Was case referred to medical examiner?	Hospital:		iont 20 DOA Oth	ar.	ath (Check only one)		
o i	this ald): To	1 Yes 2 100	1 Inpatien		IGHT 3L DOA	4 Nursing F	lome 5 Residence 28d. Describe how in		ecify)
Division of Vital	nding Photh.	Certification:	1 ☑Natural 5 ☐ Pending	(Month, Day	Year) Injur	y Wor	k? Yes 2□No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
N S	Attender death rector:	iflea	3 Suicide 6 Could r		y - At home, farm,	street, factory, office		28f. Location (Street		Rural Route Number,
	rs after or rail Dis	Cer						City or Town, St.	•	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	one)	g Physician: To the best of Examiner: On the basis of a and manner stat	examination and/or	investigation, in my o	pinion, death occu	irred at the time, date a	and place, and du	e to the cause(s)
1	To Con	Σ	29b. Signature and title of certifier		100	29c. Licens	128)6	29d. [Date signed (Mon	nth, Day, Year)
-	I/V		30. Name and address of person	0	ath (Item 23a) (Typ	e, Print)	. 1 0		- h-	200
	Sta	te	31. Date liled (Month, Day, Year)	32 Registrar	's Signature	22 yr	many 1º	H []	7700	70 2160/
42	Registr		JUN 2	3 2004	's Signature	Specker				
DHA	IH 17 Rev 1/2	201			,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vea **Physician** 11:46 PM WILLIAM JOHN HUNT JUNE 23 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner OUEEN ANNE'S STEVENSVILLE 902 MARION QUIMBY DRIVE If Under 1 Year If Under 24 Hrs. Min. As Date of Birth (Month, Day, Year)

AUG. 31, 1920 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**™** M 2□ F 83 MARYLAND 214-18-0292 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rai', or iteme 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No STEVENSVILLE QUEEN ANNE'S Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21666 USA 902 MARION QUIMBY DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or linar any injury or other traumatio. 1 Yes 2 □ No 1 ☐ Never Married 2 ☐ Married WHITE 1 Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced þ Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CONTRACTOR/DEVELOPER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LULA J. PEACH WILLIAM JOHN HUNT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3300 DANMARK DRIVE, GLENWOOD, MD NANCY NICOLA/DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ST. PETER S CATHOLIC CHURCH CEMETERY 1 X Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 75 ☐ Other (Specify) 06/26/2004 QUEENSTOWN, MD 21. Signature of Junital Aice Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Von /Medical Due to (or as a consequence f): **Examiner** conce Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami attending physicien and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 → Phiknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 esidence 6 □Other (Specify) 1 Yes 2 000 2 ER/Outpatient 3 DOA Certification: To : After this funeral of 27, Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation neral Director: A filled in by the fo 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours a 1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 39505 June 25, 2004 M. Glen Burnie, MD 2106/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

dhish Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

305

32. Register's Signature

8 2004 Mospita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year **ERNEST** MONROE HALPRYN JULY 2004 2:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | NOV . 10 , 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Yrs. NEW YORK Director 80 122-14-1305 Usual Residence of Decedent death with the Maryland 10a. State 10b. County ui Hygiene. other than "natural", or Items 23a or 28a-f show vent, Ite Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits QUEEN ANNE'S CENTREVILLE MD Directo 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 734 GUNSTON ROAD 21617 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, nit. Pages 1 and 2 should be filed within 72 hours after narment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than "natural; or Ite Injury or other traumatic event, Ite Medical Exercise Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð Specify: 3 ☐ Widowed 4 M Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **ENGINEER** ITT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN HALPRYN ANNA AGNES NEWMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SUZANNE WOODWORTH/ DAUGHTER 734 GUNSTON ROAD, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 Burial 2 XCremation 3 Removal from State 7-3-2004 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. A 23a. Part1. Enter the disease, or complic shock, or heert failure. List only one ellons it Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ineuman 10 00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and as the burial-transit the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal deeth 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 🗆 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 70 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred ospital or Attending hours after death. Natural 2 Accident 5 Pending Director: / investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide determined To the Hospital within 24 hours are To the Funeral Completely filled in Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 8 2108

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

General House

32. Registrar's Signature

2004

			1 - State of Maryland / Department of Health Certificate of Deat			0001	
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No	KUU!	22103
ı	Physic	an		Month	Da		10:10 A M
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 8/18 6000 4b. City, Town, or Location	JONE TONE	-	. County of Death	
	Exami	iei	DOCTORS COMMONITY HOSPITALLUCKED. LANH,				PEOLGES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	der 24 Hrs. 8. Date of B	irth		
	Director		579-54-156/ 1 M 20 F 64 Yrs. Months Days Hours	s Min. (Month, D	ay, Year)		nplace (State or Foreign Intry) NESOTA
	pu ,		Usual Residence of Decedent	1010	111	0 17/11-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	aryla shov	-	10a. State 10b. County 10c. City, Town or Location M D				10d. Inside City Limits
	he M	Director	MO PRINCE GEORGES RIVERDALE				1 Yes 2 □ No
	with t	Ē	10e. Street and Number 10f. Zip Code 20737	_	10g. Cit	izen of What Cou	intry?
	eath	Funerai	100/0/			An	NERICA
	ter d	Ë	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexic	Origin? (Specify Yes or N can, Puerto Rican, etc.)	0-	 Race - Amer Black, White 	
93	urs ai	by	3 Widowed Divorced If Yes, Give 1 Yes 2 No Special Year or Dates:	ify:		Specify: WH	ITE
21215-0036	be filed within 72 hours after death with the Maryland ntal Hyglene. so other than "natural", or Items 23a or 28a-f show event, the Madical Exantral for mat be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. K	ind of Business/li	ndustry
215	within 7 ene. than "r	Completed	(Specify only highest grade completed) (Give kind of work done during m life. DO NOT use retired)	nost of working	_	7	•
	ed wi	Con	12 4 BUYER		K	ZETAIL	
nd	ad oth	Be		ther's Name (First, Middle			
<u>X</u>	ould Men Merka Mer	2		VELYN IK			
Maryland	12 sh and r risir		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num ALAN HAGEN - Brother 4709 ONEENS/W				
-	ges 1 and 2 should it of Health and Mer If itam 27 is marks or othar traumatic			and the same of th	-		
Baltimore	ages 1 av nt of Hea : If itam		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	June 30,	_	ocation - City or T	
亞	permit. Pag Department Important: any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Fun Service and Address of Fac	2004	treo	erick,	Maryland
Ba	permit Depart Import any inj once.		21. Signature of Fun Service Communication (22. Name and Address of Fac 950) U.S. Rock	ute 15 N. Fr	reder	ick, MI	21701
		-				-	Approximate
	44.00		23a. Paper. Enter the disease, or correct disease, or correct disease the death. Do not enter the mode of dying, such a shock, or deart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	A			IWEEK
	Examiner		PHENDER OF STREET POR	and were de	500		YEARS
		ner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	CON ARY DE	SWI		1 crus
	ransi	Examiner	that initiated events				
ő,	be executed sician and burial-transit	İEX	resulting in death) Last Due to (or as a consequence of):				
8760	cate ohy the	dicai	d.				
9 ×	eath certific attending p I for use as	/Me	IF FEMALE:		-		
Вох	attendation	ian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		1 3	23d. Date of deliv Month	ery Day Year
o.	that the de ed by the a detached t	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown				
۵.	that led by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I. 23e. Did	obacco u	se contribute to t	he cause of death?
Records,	law requires that the death certific as been signed by the attending t 2 should be detached for use as	d by	CARCINOMA OESOPHAGUS	11	Yes 2[□No 3□Prot	pably 4 Unknown
00	s been si should	Completed	ZADIATION ANOMAONITIS	24a. Was	an	24h Wara auto	ppsy findings available
	The lay	mo		auto.	psy ormed?	prior to co death?	impletion of cause of
Vital		d	25. Was case referred to medical 26 Plan 26. Pla	1 ☐ Yes	2 No	1 Yes	2 No
	Physician: this certific ral director,	To B	examiner?	Nursing Home 5 ☐ Resi		☐Other (Specif	(v)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. late of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe			,,,
0	uttandiu death. ctor: Aly y the fu	atic	2 Accident investigation M 1 ☐ Yes 2 ☐	□No			
Division	or Attance after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and	Number or Rura	al Route Number,
	spital ours al naral D						<u> </u>
	a Hospital 24 hours a a Funaral I etely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date a company one) Add manner stated.	and place, and due to the eath occurred at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Mec	one) and manner stated. 29b. Signature and title of certifier 29c. License number			signed (Month,	
	⊢ ≯ ⊢ ŏ						
			30. Name and address of person who completed cause of death (item 23a) (Type, Print)		JUN	E 88, 30	-04
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEMA YADLA 9470 ANNAROUS RD, SUITE 3	305 (41)4	10	MA 2	0706
	Sta	e	31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	~3 ~~~	7100		-107
	Registra	ar	JUN 3 0 2004 Beneva & Son	//			

		ı	. FOI	epartment of Health and M		ene . No 2004 22101
	Physici /Medio		Decedent's Name (First, Middle, Last) Nancy Jo Haupt		2. Date of Death Month	7, 2004 1:30 A M
)	Examir		4a. Fecility Name (If not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 N F 60 Y	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 05/25/1	(eer) 9. Birthplace (State or Foreign County) 944
	e-f show	ctor	10a. State 10b. County 10c. City, Town	or Location fferson		10d. Inside City Limits 1 ☐ Yes 2 X No
	h with th	ai Director	5704 Burkittsville Rd.	10f. Zip Code 21755	100	j. Citizen of What Country? USA
036	within 72 hours after death with the Maryland ane. than 'natural', or iteme 23e or 28e-f ehow the Missies Exactines items the rutified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho lene. than "naturi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupetion Give kind of work done during most of work life. DO NOT use retired) Secretary		kb. Kind of Business/Industry elementary school
Maryland 2	wild be fited Mental Hygi arked other atic event.	To Be C	17. Father's Name (First, Middle, Last) Maurice Grossnickle	18. Mother's Nam Ruby	e (First, Middle, Ma Hockman	
Man	and 2 sho alth and 1 27 le mu er treumu		19a. Informant's Name/Relationship (Type, Print) Wayne Haupt (Husband)	Mailing Address (Street and Number or Ru 5704 Burki	ral Route Number, C ttsvill	city or Town, NFT3 Zip 22 0 1755 e Rd., Jeffe rson :
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show amy injury or other traumatic event. Its Medical Examinar measible rutilised at QDCs.			Disposition (Name of Sandon Vilewood Church Brethren Cemetery Donald B. Thomp 31 E. main St.,	7 6/10 <u>/0</u> Son Fun	c.Location - City or Town, State 4 Burkittsville, MI eral Home town, MD 21769
8760,	bhysicien and horizontal transit steps burlat-transit	dical Examiner	3a. Part. Enter the disease, or combications that caused the death. Do no shock, or heaft failure. List only one cause on each line. Immediate Gause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a c	protic Cardina		Interval Between
O. Box 6	death certif e attending od for use at	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
م	The law requires that the de- ste has been signed by the a bage 2 should be detached f	þ	Part II. Other significent conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?
al Records,	ysician: The law re its certificate has be director, page 2 sh	Completed			24a. Was an autopsy performe 1 \sum Yes 2,2	
Ĭ Z	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical exampler? 1 Yes 2 No Hospital: 1 Inpatient 2 R/Outs	Other	th <i>(Check only on</i> e) ome 5 ☐ Residen	ce 6 ☐Other (Specify)
Division of Vital	Jing After fune	ation:	2 Accident investigation	me of ury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred
Divis	2 2 2 6	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fare building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cau rred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
)	To t To tl	W	29b. Signature and title of certifier	29c. License number D35164		Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) O 15 W 7th St	Frederi	are 17,2004 ar. LND 21701
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	& South	· regar.	21/01

			- I icuse	State of Marylar	nd / Dep	artment of H	lealth and	Mental Hy	aiene			
		•	For State Registrar			rtificate of		_	Reg. No. 0 0 4	22105		
	Physicia /Medic		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day Year	3. Time of Death		
			Dorothy Mae	Ноу				June	21 2004	1 3:00 P ^M		
	Examin	er	4a. Facility Name (If not institution, giv		_		or Location of Deat		4c. County of De			
	Funeral	-	Frederick Me: 5. Social Security Number 6.5	Sex 7. Age (In yrs.	tal last birthday,	Freder If Under 1 Year	If Under 24 Hrs	8. Date of Bir	Freder	irtholace (State or Foreign		
	Director		214-34-0094	10 M 2 PF 65	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 7 - Z	6-38 W	est Virginia		
2	De little will it inclus aller deen will the wayland the Hygiene. do ther than "naturel", or items 23a or 28e-f show event, it a Medical Exam ar must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or L	ocation		11		10d. Inside City Limits		
Monda		jo	Md Freder		ederi					12 Yes 2 □ No		
ţ		irec	10e. Street and Number	0/		10f. Zip Code			10g. Citizen of What C	Country?		
die die		Funerai Director	807 Young	Place			21701		USA			
	items mer m	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.)	- 14. Race - Arr Black, Wh	nerican Indian, nite, etc.		
-0036	, o	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, Give 1 ⊔ Y				Specify: 8	Specify: Black		
5	naturel', or ite	Completed	15. Decedent's E	ducation ade completed)	16a. Dece	edent's Usual Occup e kind of work done	pation during most of wo	rking	16b. Kind of Busines	s/Industry		
V	than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire		· ·	j=AmIL)			
7	Hygie ther t	e Co	17. Father's Name (First, Middle, Last		Cili	w crite		me (First, Middle	, Maiden Sumame)			
מ ב	is 1 and 2 should by Health and Mer item 27 is marke other treumatic	To B	Richard A Ferguson CHRISTINE SIM					Imm 5				
Mary			19a. Informant's Name/Relationship		1				er, City or Town, State,			
e e			WINIFER CO			osition (Name of	Place 1	Vector i c	ck Md Z1 20c. Location - City of			
פר			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	omatory or other pla	Tune		FREDERICA			
			 Donation 5 ☐ Other (Special Signature of Funeral Service Lice) 		7/2010	2. Name and Addre	es of Facility	eg coop	me	2 77-07		
n	Depertion Department of the propertion of the propertion of the properties of the pr		1 hay 7. F		6	any L. 7	cours number	regeri	me th Md 21	701		
	484		23a. P. rt1. Enter the disease, or con shock, or beart failure. List only	nplications that caused the dea y one cause on each line.						Approximate Interval Between		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	mmediate Cause (Final disease or condition A CUTE GOSTOINEST					rge	Onset and Death		
			resulting in death)	Due to (or as a conse		o lave	. (10	0				
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse								
	te be executed ysician and he burial-transit	Examin	Cause (Disease or injury that initiated events	· Pespina	Terry	orre	= 55					
/60,			resulting in death) Last	Due to (of as a conse								
-	2 2	dicai	•	d								
ROX	attending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	- ·		23d. Date of d	23d. Date of delivery Month Day Year				
ň	deam e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	Month					
J	d by the a	Phys	9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					220 Did	tobacco use contribute to the cause of death?			
Ś	signed to	by	EVD - STAGE	nanever	_	andenying cause gr	0			Probably 4 □Unknown		
Records,	w requires to be a signer should be a	ietec	IDOM	M 24a. Was an						24b. Were autopsy findings available		
Ě	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours elfer death. To the Funeriel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it	Completed						auto perfo 1 Yes	prior to death?	completion of cause of		
Vital		BeC	25. Was case referred to medical examiner?					ath (Check only				
o ;		P	1 ☐ Yes 2 ☑ No		ER/Outpatie	AIL 30 DOX	1.12	,	dence 6 Other (Sp	pecify)		
מחכ		tion:	27. Manne Peath 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	how injury occurred	njury occurred						
Division		Certification:							at and Number or Rural Route Number,			
á,		Cert	4 Homicide building, etc. (Specify) City or Town, St						WII, State)			
		edicai	(Check only 2 Medical Exa	Physician: To the best of my kn aminer: On the basis of examin								
		Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)		
•	F 3 F 8								6-22-	0-22-04		
	3		30. Name and address of person who	completed cause of death (Ite		e, Print)						
	J			eath ST.		PERICK	MD	1071				
· .	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	4	bank!	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For Stete Registrar	State of Ma	ryland				lealth and I Death	Mental Hy	/giene Reg. No		22100	
913	Physicis	an l	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year								3. Time of Death			
	Physicia /Medic	al	Donald Beachley Huffer June 22, 2004									2:30 PM	1	
	Examin	er	4a. Facility Name (If not institution, give Beverly Health		iter		or Location of Death			4c. County of Death Frederick				
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. last birthday) If				1 Year Days	If Under 24 Hrs Hours Min.	8. Date of B			Birthplace (State or Foreig Country) MD	ın
	Director		217 30 7177	Дж и 2□ F	74	Yrs.	Months	Months Days Hours Min.		8. Date of Birth Month, Day Ye Aug. 1,		, 1929 MD		
d 21215-0036	ow ow		Usual Residence of Decedent 10a. State 10b. County										10d. Inside City Limits	5
	a-f sh	Director	MD Frederick Middletown								1 ☐ Yes 2 🙀 No)		
	with the	10e. Street and Number 6521 Holter Rd. 21769					10g. Ci	tizen of What USA	Country?					
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or flems 23a or 28a-f show event, the Macical Examiner must be rotified at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Dece Yes, spe		ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	0-		merican Indian, thite, etc. hite	
	thin 72 hou e. an "natura Modical E	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						(ind of Busine	ss/industry				
2	filed wil Hygien other th	To Be Con	8			da	iry	far	mer 18. Mother's Nai	no (First Middle		rm ow	ner	
Maryland 2121			17. Father's Name (First, Middle, Last) Josephus T. Hu	ıffer					Margar					
aryi	2 should be and Mental is marked o		19a. Informant's Name/Relationship (7	ype, Print)			•		and Number or Ri	ıral Route Numi	ber, City	or Town, State		_
	and 2 eaith a m 27 is		Greta Huffer (W	life)					r Rd.,		-			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cem	e of Dispo etery, cren hera	natory or o	ther plac	ery 6/2	Date 26/04			or Town, State	
Balt	permit. Departr Imports any inj		21 Synture of Funeral Service Licen	april 1		22	Dona 31 E	1Addres M	B Thomain St.	pson H	une llet	ral H own,	ome MD 21769	
ľ			33. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	7 80. W.									
	Examiner		Due to (or as a consequence of):											
X.	icate be executed physician and sthe burial-transit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	Due to (or as a consequence of):									
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								_			
68760,	icate be executed physicien and s the burial-transit	alE	· · · · · · · · · · · · · · · · · · ·											
_		ledical		u										
. Box	es that the death certifi igned by the attending be detached for use a	by Physician/M	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Control of pregnancy 23d. Date of delifement							delivery Day Year				
P.O.	hat the d by the	Phy	1 Yes 2 No 3 Pro								to the cause of death?	-		
ds,	uires t signe Id be c										Probably 4 Unknown	1		
CO	s been si should	olete									24b. Were	autopsy findings available	Э	
Re	The lay	omi								auto peri 1 🗆 Yes	opsy formed? 2 No	death		
/ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
6	Physic this c	.T	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3						DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred					
0	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use a	ation	1 Natural 5 Pending (Month, Day Year) Injur								200. Sociolo non inquiy occanos			
Division of Vital Records,		Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of Inju							ion (Street and Number or Rural Route Number, or Town, State)			
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the To the Comple	Me	29h Signature and title of certifier				29	29c. License number		29d. Date signed (Month, Day, Year)		_		
) MA3						•		6	121/14		
	10		30. Name and address of person who	completed cause of d	eath (Item 2	За) (Туре,	Print) M	1991	eters W	6	7	•		
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signatur	8	,							
	Registr	ar	OMILI	o sing >	Sauce	N	19	1	n. N. 1 -					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:30 P George Robert Nelson Hitchcock June 24. 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring
If Under 1 Year | It Under 24 Hrs. |
Months | Days | Hours | Min. | Brooke Grove Nursing Center Montgomery 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Director 94 20, 1909 218-24-6248 Maryland Nov. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or Itams 23s or 28s-f show event, the Medical Examiner must be notified at Maryland Sandy Spring 1 ☐ Yes ¾☐ No Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20860 18131 Slade School Road by Funeral U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Principal Schools if Health and Mental Hygi item 27 is marked othar other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be George A. E. Hitchcock Claire Virginia Lantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George David Hitchcock - Son 1904 Dulany Place, Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 □ Burial 2 □ Cremation 3 □ H 4 □ Donation 5 □ Other (Specify) 2 Cremation 3 Removal from State Mt. Carmel Cemetery 6/28/04 Sunshine, Maryland 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition SEIZURE **Physician** DISORDER resulting in death) /Medical Due to (or as a consequence of): Examiner CEREBROVASCULAR Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical asi signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? page this certificate 1 ☐ Yes 2 No of Vital ector. 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Vision 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D Ø056132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURIANA, MO 400 CLNEY-LAYTONS VILLE RD UNEY, MO 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2004 Drown Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Donald Thomas Knauss 21, June 2004 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 219 Arundel Beach Road Severna Park Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Sep. 26, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Min 15 M 2 ☐ F 69 162-32-0771 Yrs. Director 1934 PA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h Counts 10c. City, Town or Location 28a-f show itam 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic avent, the Manical Examiliar and the milliar at MD Anne Arundel Severna Park 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 219 Arundel Beach Road Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 195 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If itam 27 Is marked other than "natural", or Iter 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1962 White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) U.S. Department College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer 5+ of Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva Diefenderfer Ralph Knauss 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Knauss/Wife 219 Arundel Beach Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 25, ö 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Crownsville, MD MD Veterans Cemetery * 4 ☐ Donation _5 ☐ Other (Specify) 21. Sign the of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD Part . Enter the disease, of con shock, or part failure. List only Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immer late Ca se (Final distance or condition resulting in reath) Enysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ρō in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Cther (specify) P.0. the 9 Unknown 9 Unknown à Atter this certificate has been signed l funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 4 SUnknown Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home Certification: To 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA No Psidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manyfer of Death 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funaral Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainly as scaled.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one within 2 29b. Signatu 29d. Date signed (Month, Day, Year) 22 30. Name cause of death (Item 23a) (Type, Print) 32. Restrar's Signature 31. Date filed (Month Registrar

			For State Registrar	State of Mary	_	artment of I			ene g. Nd. 2004	22109
F	Physici	an	Decedent's Name (First, Middle, Last) Trimothy: Decident	volho				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Timothy Brian 4a. Fecility Name (If not institution, give si			4b. City, Town,	or Location of Dea		2, 2004 4c. County of Death	6:30 A M
			333 Cedar Grove Rd		1-01-int-d-1	Edge	ewater	D. D. ARIAN	Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 217–78–6476	M 2□F 43	yrs. last birthday) Yrs.	Months Days				place (State or Foreign otry) "land
	nyland how		10a. State 10b. County	10	c. City, Town or Lo	ocation			1	Od. Inside City Limits
	death with the Maryland ms 23e or 28e-f show Linual be confilled at	ecto	Maryland Anne Aru	ndel	Ec	lgewater		10	g. Citizen of What Cour	1 ☐ Yes 2 🙇 No
	3a or	DI	333 Cedar Grove Rd				037		USA	
	er deat	Funeral Director	11. Marital Status	Was Decedent Ever Armed Forces?	r in U.S. 13.			Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
5-0036	2 hours after death with latural, or Items 23a or ical Exam ar must be	þ	1 ☐ Never Married 2次 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Whi	te
<u>2</u>	n 72 hours natural',	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking 1	6b. Kind of Business/In	dustry
717	d within 72 giene. rr than "nai	omo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Roofer			Construc	tion
land	be filed ital Hygi of other event.	Be	17. Father's Name (First, Middle, Last)	olbo Cr			18. Mother's Na	me (First, Middle, M		
	shoutd nd Men marke umatic	²	William Henry Ko		19b. Maili	ng Address (Stree	t and Number or R	Nancy Jea	an Carr City or Town, State, Zip	Code)
, Mai	12 P P P P P P P P P P P P P P P P P P P		Christine C. Kolb	e/ Wife	333	Cedar Gr	ove Rd.,	Edgewater	, MD 21037	y_
Jore	ges 1 t of H if ital		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re			osition (Name of matory or other pla trematory		Date 2	oc. Location - City or To Edgewater,	
Baitimore,	mit. Pag partment portant: / injury o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	9		_			Kalas Funer	
ñ	P P P P P		23a. Part 1. Enter the disease, or complic		2	973 Solo	mons Isla	and Rd. Ed	lgewater, M	D 21037 Approximate
/60,	Physician /Medical Examiner per prize priz	cal Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ONCRUS.	insequence of): We fast insequence of): insequence of):	ASK	r Sacus	WE		Interval Between Onset and Death
O. Box 68	death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	sy		23d. Date of delive	ory Day Year
ds, P.	uires that signed b d be deta	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause g	ven in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
al Records,	uician: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to condeath?	psy findings available inpletion of cause of
Vital	S S D	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA O	her	ath (Check only one Home 5 Hesider) nce 6 ⊡Other (Specifi	/)
on of	ding Afte fune	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	We	ary at ork?]Yes 2 □ No	28d. Describe how	v injury occurred	
Division	al or Attandi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (Stree City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and little of entities	1		29c. Licen	se number	29	d. Date signed (Month,	Day, Year)
			Cully H	ann 1	44	Doing)	1306		6/22/0	4
			30. Name and address of person who co	mpleted cause of death	Bestaur	h plat	Stezii 1	Annolis,	6/22/0 AB 2140	/
	Sta Regist		31. Date filed (Month Car Year) 20	32. Rigistrar's	Signature	boul		7		

			For Stata Registrar	State	of Ma	aryland / Depa <i>Cei</i>	artment of H		nd Ment		iene	nI.	221	10
I	Physici	an	1. Decedent's Name (First, Middle, La						_N	ate of Death	1	2004	3. Time of	Death
	/Medic Examin	al	Stella Pastovich 4a. Facility Name (If not institution, gir		ımber)		4b. City, Town, o	or Location of		ine	4c. County		6:00) PM
	EXAMILI	er	Anne Arundel Med				Annapoli				Anne		e1	
	Funeral Director		296-18-9878	Sex 1□M 2只F	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. Jul	ate of Birth Month, Day, Ly I2,	1923	9. Birthp Coun Ohio	lace (State or try)	r Foreign
	and aw	-	Usual Residence of Decedent 10a. State 10b. County			10c. City, Town or Lo	cation					1	0d. Inside Cit	ty Limits
	Mary a-f sho	tor	Maryland Anne Ar	ınd e 1		Annapolis	;						1 🗆 Yes	2 ⊋ No
	or 286	Oirec	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Coun	try?	
	s 23a	ral	728 Springdale A		F		21403				nited			
36	irs after de il', or Itam Xaminarz	by Funeral Director	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Dec Armed F 1 Tes If Yes, G Year or	orces? 2 X N ive	lo	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	Specify:	Puerto Rican	res or No- 1, etc.)	Blac	e - Americ ck, White, o y: Whi	etc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic evant, the Medical Examinar rutal be notified at ODGe.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed College		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working	1	6b. Kind of B	usiness/Inc	lustry	
2	led wii tygien har th nt, the	Con	1.2 17. Father's Name (First, Middle, Las			Homema	ker	10 Mathe	da Niama (Circ		Own Ho			
anc	d ba fi	o Be	Nick Pastovich	,					upusan		laiden Suman	ne)		
Maryland	shoul and Me s mark umati	9	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street				City or Town,	State, Zip	Code)	
Σ,	and 2 ealth a m 27 is		Peter C. Lisko	Son		5125	East Des	ert Vi	sta Tr	cail C	avecre	ek, A	Z <u>8533</u>	1
ore	ages 1 nt of H : If ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [State	Centerery, Cren	natory or other plat	20)						
Baltimore,	artmer ortant injury	1	*4 □ Donation 5 □ Other (Special 21. Signature of Fulleral 7 of the			Baltimore	. Name and Addre		29/200		altimo aylor :			
B	per Imp any		Mich // Il	inge			47 Duke		JOH					
1000	Fnysician	6 4	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that one cause on a	caused each lin	the death. Do not entre.	er the mode of dyir		ardiac or resp	G V	st.		Approximate Interval Betw Onset and D	veen
	/Medical Examiner			Due to	(or as a	a consequence of):							/	
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a	a consequence of):								
ó	icate be exacuted physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to	(or as a	a consequence of):								
8760,	ate be hysicia the bur	dicai	(d										
.O. Box 6	ath cartif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		birth nant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	′			23d. Dai Mo	te of delive		ear
Δ.	uires that the de signad by the Id be detached	by	Part II. Other significant conditions	contributing to	death bu	t not resulting in the ur	nderlying cause giv	en in Part I.	2		acco use cont	nbute to the	1/	nknown
Records,	aw requir as been si 2 should	Completed							2	24a. Was an autopsy		Nere autop	psy findings an	vailable
		Com		_	,				1	perform	ed?/	death?		u3 0 01
Viital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	/		Oth	or	of Death (Che					
	g Phys ar this eral dii	n: To	1 Yes 22No 27. Manner of Death	28a. Date	Inpatie	y 28b. Time of	1 3 DOX	4 14013			rce 6 □Oth v injury occurr		1	
ion	ttanding F death. stor: After the funera	atio	1 Natural 5 Pending investigation	n	nth, Day	Year) Injury		k? Yes 2 □ N	lo					
Division of	il or Attano after death Diractor: d in by the	Certification:	3 Suicide 6 Could not 1 determined	289. Plac	e of Injuding, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. L	ocation (Stre lity or Town,	eet and Numb State)	er or Rural	Route Numb	er,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funaral director.	Medical C	29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the miner: On the land mai	dasis of	f my knowledge, death examination and/or invited.	occurred at the tire restigation, in my o	ne, date and pinion, death	place, and du n occurred at t	ue to the cau the time, dat	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)	
•	To the within To the comp	Ň	29b. Signature and title of certifier	Orra	Va	a mo	29c. Licens	e number	15	290	d. Date signed	(Month, C	lay, Year)	
		5.01	30. Name and address of person who	completed cau	ise of de	eath (Item 23a) (Type	Brint)	Av	T. A	DAGA	10/11	M	D	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 28	2004	gistra	r's Signature	book		/	7				

	,	For Stata Registrar	State of Marylar		artment of F				ne . No 2 0 0 4	22111
Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Last) CRAWFORD CRAI 4a. Facility Name (If not institution, give	G LOLLER street and number)		4b. City, Town, o	r Location o	J	ate of Death fonth	Day Year 5 2004 4c. County of Dea	3. Time of Death 8:30a
Funeral Director		50 Locust Poin 5. Social Security Number 212-26-1809 Usual Residence of Decedent		last birthday) Yrs.	Elkto If Under 1 Year Months Days		24 Hrs. 8. Da Min. Ju	ate of Birth Month, Day, Yo 1y 18	Cecil 9. Bir 1910 M	rthplace (State or Foreign ountry) aryland
the Maryland 28a-f show		10a. State 10b. County MD Cecil 10e. Street and Number		ty, Town or Lo	cation			100	. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examiner must be malified at once.	by Funeral Di	50 Locust Poin	t Rd. 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		21921 Vas Decedent of H i Yes, specify Cuba		gin? (Specify Y , Puerto Rican	U	. S . A . 14. Race - Ame Black, Whi	erican Indian,
nd 21215-0036 a filed within 72 hours aft a flygione. other than "neturel", or rent, the Michael Examp	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last)		(Give life. L	lent's Usual Occupi kind of work done of DO NOT use retired CENANCE	during most f) -Hand	lyman	S M	b. Kind of Business mall En anufact den Sumame)	gine
, Maryland and 2 should be fill and 2 should be fill saith and Mental Hyn 27 is marked oth retreumetic even	ToB	James Loller 19a. Informant's Name/Relationship (Ty) Kevin Loller	(son)	50	g Address (Street a	and Numbe	Rd.	te Number, C	ity or Town, State, .	
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature + Funeral Service (icense	emoval from State	Place of Dispondentery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeters, sition <i>(Name of</i> natory or other place phen's Name and Addres	Cem	Date 7-9-04	4 E a	c. Location - City or	Town, State Le, MD.	
Physician /Medical		23a. Part 1 Enter the disease, or complicators, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	th. Do not ente	8 West or the mode of dying on lop or	Cros	S St.	Galer biratory arrest,	na, MD.	L Schaech 21635 Approximate Interval Between Onset and Death
executed in and inal-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Union ying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).	quence of):	nia	b.n	en	ia		
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the second of th	/We	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🗆	Ectopic pregnancy Other (specify)	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			23d. Date of del Month	livery Day Year
cords, P. w.requires that been signed be should be deta	ρ	Part II. Other significant conditions con	tributing to death but not res	sulting in the un	derlying cause give	en in Part I.	_	3e. Did tobac 1 ☐ Yes ————————————————————————————————————	2 ØNo 3 □ Pr	o the cause of death? robably 4 □Unknown utopsy findings available
of Vital Rec Physician: The law rthis certificate has t ral director, page 2 s	Be Completed	25. Was case referred to medical examiner?					_	autopsy performed ☐ Yes 2 ☐	prior to death?	completion of cause of
ding ding h.	ertification; To	1 Yes 2 Ho 27. Manner eath 1 Hatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	4 LI Nuis	10	escribe how i	njury occurred	,
	0	4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At h building, etc. (Special ician: To the best of my known: per: On the basis of examina	fy)	occurred at the tim	ne, date and	Ci	ty or Town, S	e(s) and manner as	stated
To the I within 2.		29b. Signature and title of certifier	and manner stated.	MD	29c. License	number	149		Date signed (Monti	
5	(30. Name and address of person who co	mpleted cause of death (Item	111 1	Print)	igh	51.9	Siil	Je 302	Elkton MD 2199

			1 - For State Registrar	State of M	aryland	•	ment of F		Mental Hy	Reg. No.	004	22112
	Physici	165	1. Decedent's Name (First, Middle Betty Doris						Month June	Day	Year 2004	3. Time of Death 19:581 ^M
	/Medic Examin		4a. Facility Name (If not institution			4	o. City, Town, or	Location of Dea	ith	4c. C	ounty of Death	
		Sec.	Chester River				Cheste:		0 0 0		Kent	
Park of	Funeral Director		5. Social Security Number 145–20–4284	6. Sex 7. Ag	76		lonths Days	Hours Mir		y, Year) 3, 192	Cour	place (State or Foreign http) JERSEY
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion				1	0d. Inside City Limits
	ith the Marylar or 28a-f show	to	MD QUEE	N ANNE'S	CI	ENTREVI	LLE					1 ☐ Yes XX No
	th the	lrec	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Citize	n of What Cour	ntry?
	ath wi	rai	302 CREAMERY				2161			US		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "netural", or Items 23a or 28a-f show other traumatic event. Ite Madical Evaluations and Evaluating at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marriad 3 🕱 Widowed 4 ☐ Divorced	If Yes Give	,		s Decedent of Hess, specify Cuba	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		I. Race - Americ Black, White, Specify:	
50	72 hc	eted	15. Deceden (Specify only highe	it's Education st grade completed)		(Give kin	t's Usual Occup d of work done	durina most of w	orking		of Business/Inc	
7	within ene. then '	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		NOT use retired ORDINAT				FACTURIN	
	Hygin other ent.	Be Cc	17. Father's Name (First, Middle,					18. Mother's Na	ame (First, Middle	, Maiden S	umame)	
<u>lan</u>	ihould be id Mental marked c	To B	GEORGE PARK	ER PEAK			a di	MURI	EL MARIE	ROBE	SINS	
Maryland	2 should and Men Is marke		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing A	Address (Street	and Number or F	Rural Route Numb	er, City or	Town, State, Zip	Code)
	s 1 and if Health Item 27 other tr		PAMILA BOONE/ 20a, Method of Disposition	DAUGHTER	20h Pla	504 GR		ANCH ROA	D. CHURC		L, MD 2	
פֿר	nt of h	1	1 Burial 2 Cremation		cer	netery, cremat	ory`or other plac	ERY 6-2				
Baltimore,	permit. Pages Department of H Importent: If Ite any injury or of		* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	-	CHES		ame and Addre	1	J-2004	CENIK	EVILLE,	MD
B	permi Depa Impo any ii		1 Thomas K	Hellenhow	ì	FEL 408	LOWS, HE	LFENBEIN	& NEWNA	M FUN	ERAL HO	ME, P.A.
September 1	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Ca	d the death. bl a conseque	adde	ne mode of dyin	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						
.O. Box	death certif e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal c	death 3 ⊟Ed	topic pregnancy ther <i>(specify)</i>			23	d. Date of delive Month	ery Day Year
Vital Records, P	The law requires that the ste has been signed by th bage 2 should be detache		Part II. Other significant conditi	ons contributing to death t	out not result	ting in the unde	rlying cause giv	en in Part I.				ne cause of death?
000	e law re has bee	Completed							24a. Was		24b. Were auto	psy findings available mpletion of cause of
Ĕ		E							perfo 1 ☐ Yes	ormed2	death?	
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				100		eath (Check only			
of	hys this al dii	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpati		R/Outpatient 28b. Time of			Home 5 ☐ Resi			y)
no	ding h. After fune	tion	1 ☑Natural 5 ☐ Pendi	/Adometh /Te	y Year)	Injury	28c. Injur Wor	yat k? Yes 2 □ No	200. Describe	now injury	occured	
Division	after death. I Director: After d in by the fune	Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide	not be 390 Place of In	jury - At hom tc. (Specify)	ne, farm, street			28f. Location (City or To		Number or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	ledical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner si	of examination	eledge, death or on and/or inves	ccurred at the tir tigation, in my o	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	nd manner as si lace, and due to	ated. the cause(s)
	To the within 2. To the complete	Me	29b. Signature and title of certific	er O			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			1/1/1	IVV	1		D0051	1786		JUNE	23,200	4
	TYK		30. Name and address of person ANDREW S. FEI	who completed cause of	death (Item 2	23a) (Type, Pri	nt)	IESTERTO	WN. MD 2	1620		
	Sta	ate	31. Date filed (Month, Day, Year		A 01							

			1 - For Stete Registrar	State of Marylan	•	artment of F			giene Reg. NØ?		221	13
П	Physici		Decedent's Name (First, Middle, Las John	Joseph		McDonne	:11	2. Date of Dea Month July	1, 200	Year 4	3. Time of 9:05	Death A ^M
	/Medic Examin		4a. Facility Name (If not institution, give 12400 Stonehaven	Lane		Bowi					Georges	s
	Funeral Director		1/4-40-1421	XM 2DE	last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, Year) , 1948	9. Birthp Coun Penr	lace (State of htry) 1Sylvat	r Foreign nia
Baltimore, Maryland 21215-0036	perinit. Tages raing a should be lined writtin for industries drain with the wayyand beginned of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or Items 23a or 28a-f ehow any injury or other treumatic event, its Medical Examination could be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge 10e. Street and Number 12400 Stonehaven 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) John 19a. Informant's Name/Relationship (7 Jennifer McDonne) 20a. Method of Disposition 1 Burial 2 Cremation 3 County (10-12) 21. Signature of Funeral Service Licenty	Lane 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Lucation Le completed) College (1-4or 5+) 4 Mc Donnell Lype, Print) Let 1 / Wife Removal from State Hun See	16a. Dece- (Give iife.) ACCOU 19b. Mailii 12400 Place of Disposemetery, crait tt Cre	Was Decedent of I- If Yes, specify Cubi I Yes, specify Cubi On Or Usual Occup kind of work do ne and North Serve Int Represent	specify: pation during most of we during most of we sentativ 18. Mother's Na Evelyn and Number or F ven Lane (29) 7/7 ss of Facility R polis Ro	Specify Yes or Norto Rican, etc.) orking e ame (First, Middle, Grac Rural Route Numbe , Bowie, Date 7/2004 obert E. ad, Bowie	14. Rac Blac Specify 16b. Kind of B Industrate Maiden Suman ce r, City or Town, Marylar 20c. Location - Valdorf; Evans le, Mary	What Courses Americal White, who was in early State, Zip and 2 City or To Mary Funer.	an Indian, etc. ite dustry Equipm is Code) 0715 wn, State yland al Home	2 No
E	/Medical /waminer	cal Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)	uence of):		1001111001	acor respiratory ar	Orași.		Approximate Interval Betwo Onset and D	ween
Hecords, P.O. Box 68/60,	y the attending phiched for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnanc	1			te of delive	*	'ear
ds, P	n signed by the a	by	Part II. Other significant conditions co	ont <i>r</i> ibuting to death but not res	ulting in the u	nderlying cause giv	en in Part I.		bacco use cont es 2 □ No		e cause of de	
I Records,	ystolett. The taw requires services is certificate has been si director, page 2 should	Completed						24a. Was a autop: perfor	med?	prior to con death?	osy findings an pletion of ca	ivailable luse of
<u> </u>	certificate	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or	10)			
Division of Vital	Attending Filysicien. r death. ector: After this certifics by the funeral director.	은	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	28b. Time o	f 28c. Injur Wor	4 Ivuising	Home 5 Resid			')	
DIVISI	E S S S	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the second of the s		reet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	Route Numb	er,
	within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) 2 Medicet Exem	vsicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, o	ause(s) and ma late and place,	inner as stand due to	ated. the cause(s)	
	vithin To the comple	M	29b. Signature and title of certifier	June 40		29c. Licens	e number 43 fv	2	29d. Date signed \mathcal{F}	(Month, L		
			30. Name and address of person who of Kai-Yiu Yeung, M.			Print)	·	. Marvlar	nd 2073	·		
	Sta Regist		31. Date filed (Month, Day, Year) JUL 0 2 2	32. Signatura Si		hack	311116011	, ,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#26 per Phy 6/29/04 State of Maryland / Department of Health and Mental Hygiene AA (

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I	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of I	Death Death 24	ay .	Year 2004	3. Time of Death	
	/Medic	al	Jessie McAvoy	-AA			4h Cihi	Tour or	Location	of Dooth	June		c. County		7:54 a N	_
	Examin	ier	4a. Facility Name (If not institution, give 502 Burning Tre				4b. City,	Arn		or Death			Anne		nde1	
	Funeral		Social Security Number		(In yrs. last bir	thday)	If Under	1 Year	If Under		8. Date of E (Month, L				lace (State or Foreig	n
	Director		076–32–4175	□M 2 X]F	63	Yrs.	Months	Days	Hours	Min.	Dec.	15,	1940	Cour	NY	
	put *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation							1	Od. Inside City Limits	
	Maryla f sho	ō	MD Anne A	rundel				Arr	nold						1 ☐ Yes 2 🛣 No	
	death with the Maryland ms 23a or 28a-f show froust be notified at	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of W	/hat Cour	ntry?	_
	h with		502 Burning Tre	ee Drive				2	21012					USA		
	ems arm	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Was Deced				ecify Yes or I Rican, etc.)	VO-		- Americ	ean Indian,	_
20	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ★ No If Yes, Give)	1	1 🗆 Yes		Specify:		,		Specify:		White	
9500-61212	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it a Medical Exertiner must be notified at	ed b	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	16a	Decer	dent's Usua	al Occupa	ation			16h k	Kind of Bu	siness/Inc	duetry	_
Ç	n na	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give life. L	kind of wo. OO NOT us	rk done d se retired	during mos	st of worki	ng	100.1	tilla of ba	311033711	Justiy	
7 7	d with giene er tha	mo;	12	College (1-401 54	,		Home	emake	er				Hom	ne	. —	
land	be file lal Hy d othe	Be (17. Father's Name (First, Middle, Last)								(First, Midd		n Surnam	θ)		
<u>Y</u> a	Men Men arke	2	Michael LaCorte								ne Loc					
Mary	d 2 sho th and th sma 7 is ma trauma		19a. Informant's Name/Relationship (7 Thomas J. McAvoy		195		-				ve, Ar	-		State, Zip	Code)	
	1 an Heal em 2 thar	1 3	20a. Method of Disposition	/ Husbaria	20b. Place o	f Dispo	sition (Nan	ne of	1		ate	_	ocation -	City or To	wn, State	
o L	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		Hillcr	-	natory or o Memo		<i>e)</i>	June 200	28,	Anı	napol	is.	MD	
galtimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licen		1111101				s of Facili	ty D	J4				neral Home	_
ñ	Per Per Per Per Per Per Per Per Per Per		Thomas !	Mh		4	95 G	ov. I	Ritch	ie H	.A. se wy, se	verna	a Par	k, M	neral none D 21146	3
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused tone cause on each line	he death. Do	not ent	er the mod	e of dyin	g, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between	
	Physician	d bi	Immediate Cause (Final disease or condition	. (me	1									Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):										
	LAGITITIES	<u>_</u>	Sequentially list conditions,	b. Due to (or as a	COREGUIORCO	of):								-		
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or him y that initiated events	Due to (01 a3 a	consequence	Olj.										
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):								-		_
68/6 0,	ysicia ysicia			d												
9	the death certilicate be executed y the attending physician and tched for use as the burial-transit	Medical	IF FEMALE:													
o a	ath ce ttendi or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2	Fetal death		Ectopic pr						23d. Date Mon	of delive	ry Day Year	
5	the a	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	5 [Other (sp	ecify)								
Ţ.	n requires that the death been signed by the atte should be detached for	h h	Part II. Dther significent conditions co	entributing to death but	not resulting in	n the ur	nderlying c	ause give	en in Part I	l.	23e. Dio	tobacco	use contri	bute to th	e cause of death?	_
g Q	The law requires that ite has been signed b age 2 should be deta	d by									1 🗆	Yes 2	No	3 🗌 Prob	ably 4 Unknown	1
cords	s beer shou	lete									24a. Wa		24b. W	/ere autoj	osy findings available	Э
T T	The lavate has	Completed									aut per 1 ☐ Yes	opsy formed?	de	rior to cor eath? □Yes	npletion of cause of	
VITal		Be C	25. Was case referred to medical						26. Place	e of Death	(Check only		•		20110	_
010	d is	10 E	examiner? 1 □ Yes 2- No	Hospital: 1 Inpatien		utpatien	t 3 🗆 DC	Othe	er: 45	reing Hor	ne 5 Re	sidence	6 Othe	r (Specify	')	
	ng fter ine		27. Manner of Death 17 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of injury		8c. Injury Work	(?		28d. Describe	e how inju	ry occurre	ed		
<u>8</u>	or Attending Futer death. Director: After in by the funera	cat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of Injur	ar At home fo		M		Yes 2□		39f Location	(Etropt a	nd Mumbo	r or Dura	l Route Number,	
UIVISION	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	irm, stre	eet, ractory	/, OΠICΘ				own, State		r or Hura	Houte Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 15 Certifying Phy	sicien: To the best of	my knowledge	e, death	occurred	at the tim	ne, date ar	nd place, a	and due to th	e cause(s	and mar	ner as st	ated.	_
	n 24 h	Medical	(Check only 2 Medical Examone)	iner: On the basis of a and manner state	examination an	id/or inv	estigation.	, in my op	oinion, dea	th occurre	ed at the time	, date an	d place, a	nd due to	the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier				290	. License	number	•		29d. Da	ite signed	(Month, I	Day, Year)	
								05	1868	6			6/2	5/0	4	
			30. Name and address of person who o	ompleted cause of de	ath (Item 23a)	(Type,	Print)	7		1 -	pn	14		10.5		
			31. Date filed (Month, Day, Year)	32. Registrar	's Signatura	hie	- 17	1746	2	140	JEU,	100	2	(012		
	Sta Registi		JUN 2 9 2004		-											
DH	MH 17 Rev 1/2	-0	D .7 LOOT	position.	BA	Bell	-									-

			1 - For State Registrar	State of Marylar	•	artment of H			iene	22115
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month	100 00 100	3. Time of Death
	Physici /Medio		Gilbert L. Mo	Clurg, Sr.				June 2		6:25 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Dea	ath
			Heritage Harbour 5. Social Security Number 6. Se		[act hidhday]	Annapo	olis If Under 24 Hrs	8. Date of Birth	Anne Ar	
	Funeral Director			X M 2□F 87	Yrs.	Months Days	Hours Min.			rthplace (State or Foreign country) W York
	ס		Usual Residence of Decedent					13 13	10 110	
	arylar show	_	10a. State 10b. County		ity, Town or Lo		•			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	he M	ecto	Maryland Anne Art	ındel		Annapol:	lS	1/	Og. Citizen of What C	
	Mith Ba or	à	1930 Marconi Circ	le		2140	1	1	USA	Contry
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or tlems 23a or 28a-f show ant, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No-	14. Race - Am	
9	or ite	/Fu	1 Never Married 2X Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 □ Yes 2X No	Specify:	to nican, etc.)	Black, Wh	
21215-0036	hours tural',		3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup	ation			
5	in 72	plete	15. Decedent's Edi (Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Business	windustry
212	d with giene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 3 years	Senio	or Cost Es	stimator		Aerospac	ce
2	al Hy d other	Be	17. Father's Name (First, Middle, Last)	_				me (First, Middle, N		
yla	should be ind Mental marked o umatic eve	ို	Dudley D. N		1			Carlotta :		
Mar	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, the Machical Examiner mast be notified at		19a. Informant's Name/Relationship (T) Hilda Lee McClurg						City or Town, State, s, Marylar	
<u>ნ</u>	tem 27		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of			20c. Location - City o	10.0
<u>o</u> E	Pages nent of thant; If ite ant: If ite		1 ☐ Burial 2 🂢 Cremation 3 ☐ I 3 ☐ Other (Specify,	Hemoval from State		natory or other place Crematory	1	8-04	Edgewater	, Maryland
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health s Important: If Item 27 it any injury or other tra once.	1	21. Signature/of Funeral Service Licens				ss of Facility Ge		Kalas Fune	
<u> </u>	88 5 8	(V)	10hill Clark					_	dgewater,	
***	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the dea ne cause on each line.	th. Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):	nac	tis I			1/44
3	Examiner	_	Sequentially list conditions,	b						
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consec	quence on.					
ć	be executed sicien and burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8760,	cate be ex hysicien the buria	dlcal		d						
99	artifica ing ph e as th	Med	IF FEMALE:							
Вох	The law requires that the death certificate be executed tto has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
o.	that the de ad by the a detached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	oeatri 5	Other (specify)				
۵.	res that the signed by be detact	by Ph	Part II. Other significant conditions co	intributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I	23e. Did tob	acco use contribute t	o the cause of death?
Records,	w requires been sig should by		Corosony or try	Cheine	Perg	throl U	sular	1 ☐ Ye	s 2□No 3□P	robably 4 Munknown
eco	law requas been 2 should	plet	dieser	/				24a. Was an autopsy		utopsy findings available completion of cause of
	The	Completed						perform	ed? death?	1.0
Vital	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Ch	00	ath (Check only one		
	Phys	10	1 Yes 2 SNo 27. Manner of Death	1 Inpatient 2	ER/Outpatier 28b. Time of	The second second second	4 A vursing r	lome 5 Resider	nce 6 ⊡Other (Spe winium occurred	ecify)
on	ding F th. : After s funera	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2□No		,,	
Division of	I or Attend after death Director: / Jin by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the tuneral director, page	edical C	29a. Certifier 1 Scertifying Phy (Check only one)	rsician: To the best of my kniner: On the basis of exam≀ni and manner stated.	owledge, deatl ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the ca arred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of confifier			29c. Licensi			d. Date signed (Mon	*
•	0		1 Bth	MD		D 3	8958	E	128/10	04
			30. Name an address 1 person who c	completed cause of death (Ite	m 23a) (Type,	Print)	1 1		28/20 enton M	2 0 0 0
			Da Goet Single	Siether 1413	Enna	bely Kor	0 #10	16,000	enton por	021113
	Sta Registi		31. Date (led (Month, Day, Year) JUN 2 9 2	32. Paistrar's Sign		boulle				

			For State Registrar	State o	f Maryla		artment of H				giene	004	22	116
112			Decedent's Name (First, Middle,	Last)						2. Date of Dea	ath	Vone	3. Time of	f Death
	Physici /Medic		Leo	n Met	t					June 2	3, ^{Day})04	8:00	\mathbf{P}^{M}
	Examir		4a. Facility Name (If not institution,	give street and nu	m <i>ber)</i>		4b. City, Town, or	Location of	of Death		4c. C	ounty of Dea	th	
		, 3	2313 Briarcroft		7 4 //-	tra for at high plant	Edges	water		8. Date of Birt		ne Ar		- Caraina
	Funeral Director		5. Social Security Number 112–34–0203	S.Sex XX м 2□ F	7. Age (in)	rs. last birthday) Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)		thplace (State o ountry) Oeria	or moreign
elja -			Usual Residence of Decedent		01					10-14-	1742	311	JEL 14	
	rylan	_	10a. State 10b. County		10c.	City, Town or Lo	ocation						10d. Inside C	
	8a-f.s	octo		Arundel		Edgewat								2 X No
	with the	급	10e. Street and Number	CI-			10f. Zip Code	7				on of What Co	ountry?	
	72 hours after death with the Maryland netural', or Items 23a or 28a-f show diest Evantrar must be rodified at	Funeral Director	2313 Briarcroft	12. Was Dec		n U.S. 13.	2103° Was Decedent of H		gin? (Spe	ecify Yes or No-	US 14	. Race - Am		
9	or Iten	Fun	1 Never Married 2 Marrie	Armed Fo	2 X No		Was Decedent of H		i, Puerto	Rican, etc.)		Black, Whi		
933	ral', c	d by	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve lates:		1 ☐ Yes 2 🙀 No	Specify:			S	Specify: V	White	
215-0036	"netu	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup: kind of work done of DO NOT use retired	during most	t of work	ing	16b. Kind	d of Business	/Industry	
212	within lene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		ess Admin		tor		Empl	ovee F	Benefit:	3
9	should be filed within of Mental Hygiene. marked other than imatic event, it a Mi	Be Co	17. Father's Name (First, Middle, L			Dustile	SS ACHILLI			e (First, Middle,				
<u>lan</u>	Aental Aental rked c	To B	Н	enry Met					H	elen Me	t			
Maryland			19a. Informant's Name/Relationshi				ng Address (Street a							
	permit. Pages 1 and 2 Department of Health ar Importent: If Item 27 Is any injury or other trau		Myriam Met/ Wife	e 	20		Briarcro	oft C						
Ore	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation		1		natory or other plac			Date		ation - City or		
Baltimore,	it. Partmer		* 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Springs)				Crematory		6-24		Edge	water,	Maryla	and
Ba	Deparation of the post of the		Mula 11/11/11	112	p-1-	2	2. Name and Address 2973 Solon	none	"Geo	orge P.	ката	s fune	eral Hon	ne 27
20			23a. Part1. Enter the disease, or o	complications that	caused the d							acer,	Approximat Interval Bet	le
	Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a.	Bacif inje.	ING- C	AWZIR	-					Opser and	Peath W/ ki
	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to	(or as a con	sequence of):								
	A 50 m	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a con	sequence of).								
	cuted	min	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
, 0	sate be executed obligation and the burial-transit	Exa	resulting in death) Last	Due to	(or as a con	sequence of):							ri.	
8760,	ate b	dica	'	d				···		·····				
9 x	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE:	23c. If yes, ou	tcome of ore	egnancy					22	d. Date of de	linear	
Вох	death of atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 □ F nantattime	Fetal death 3	Ectopic pregnancy Other (specify)				23	Month Month	,	Year
0	that the d ed by the detached	hysi	9 Unknown	9□ Unkr	iown									
S,	res tha signed I be det	by P	Part II. Other significant condition	s contributing to d	leath but not	resulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of c	leath?
ord	law requires as been sign 2 should be									XX	es 2 🗆	No 3 P	robably 4 🗀	Jnknown
Records,	has be ge 2 sh	Completed								24a. Was autop	sy	prior to	utopsy findings completion of c	available ause ol
<u>=</u>	The sage	Con								perfor	225 No	death?	2000	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	or:		n (Check only o				
of		. To	1 Yes 2 No 27. Manner of Death	10		2 ER/Outpatier 28b. Time o	f 28c. Injun	v at	rsing Ho	me 5 X esid 28d. Describe h		Other (Spe	cify)	
on	Attending Phyr death. sctor: After thi	tion	↑ Natural 5 Pending		of Injury oth, Day Yea	r) Injury	Worl	k? Yes 2 ∐ !						
Division	or Attendii ifter death. Director: A in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 286. Place	e of Injury - A ling, etc. (Sp		reet, lactory, office			28f. Location (S City or Tow		Number or R	ural Route Num	ber,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier Certifying (Check only one)	xaminer; On the b	pasis of exam	knowledge, deat nination and/or in	h occurred at the tim vestigation, in my o	ne, date an pinion, deal	d place, th occurr	and due to the c	cause(s) ai	nd manner as lace, and due	s stated. s to the cause(s	;)
	To the within 2 To the comple	Med	29b. Signature and tive of certifier	and that	ner stated.		29c. License	e number			29d. Pate	signe# (Mont	h, Day, Year)	
	F > F 0		> Xoter	(CXTOR	2		010	0360	4		6/2	4/00	+	
			30. Name and address of person w	no completed cau	of death	(Item 23a) (Type,	Print)	~ A	1	2764	-, 11	17,	101	
			VEDER GRA	RE MU	400 5	उत्राक्त	E K-030	NA	MA	Brich	W	WU	40)	
96	Sta Regist		31. Date liled (Month, Day, Year) JUN 2 5	2004	gistrar's S	ignature	bout !							

		1 - State Registrar	State of Maryla m #5 per fh G	Ce	ittlicate of	Deam		Reg. No. C U U	4 27
A	ં લ	1. Decedent's Name (First, Middle, La	st)				2. Date of De	eath Day Ye	3. Time of Death
Physici /Medi		Naomi Beat	rice Myers		,		July	7,2004	7:30A M
Examir	- 16	4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, o		ath	4c. County of D	
	1	Frederick Memor		a.1 s. last birthday	Freder:	1 C K If Under 24 Hr	s. 8. Date of Bir	Freder	ick Birthplace (State or Foreign
Funeral Director			1 M X F 91	Yrs.	Months Days	Hours Mir		^{v.} 1913	Mary Land
		Usual Residence of Decedent						,	
a-f show	tor	Maryland Freder:		City, Town or L Freder					10d. Inside City Limits
23a or 28 at be not	Funeral Director	10e. Street and Number 7725–A Edgewood	d Church Road		10f. Zip Code	1702		10g. Citizen of What U.S.A.	t Country?
ual Hygiene. ud other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XXo	dispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		American Indian, Vhite, etc. White
al Hygiene. other then "natur: vent, the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of w	rorking	16b. Kind of Busine	
nt. E		17. Father's Name (First, Middle, Last	1	ПОШ	emaker	18 Mother's N	ama /First Middle	o, Maiden Sumame)	le .
• d ot	Be		Elmer Blank				a Decker	, watour sumame,	
is marked (is marked (raumatic ev	To	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street			per, City or Town, Stat	re, Zip Code)
7.2		Mrs. Hope Troxel	l, grandaughte		2 Edgewoo	d Church	n Road, I	Frederick,	
Important: If item any injury or other once.		20a. Method of Disposition 14∑ Burial 2 ☐ Cremation 3 ☐ 14☐ Donation 5 ☐ Other (Special	Removal from State	cametery cre	matory or other place	etery Ju		200. Location - City 2004 Fred	
any inj		21. Signature of Funeral Service Lice	MOO:	255	Reeney an 106 East	d fasto Church	rd PA Fur St., Fred	neral Home derick, MD	21701
edical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	1	RY ART		ng, such as cardi			Approximate Interval Between Onset and Death
dical niner	al Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	equence of):	iter the mode of dyir	ng, such as cardi			Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Janey Magee MacFawn 19:40 [™] JULY 7 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Jan 28, 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 M 2 X Yrs. 82 Director ÑΥ 1922 035-14-2273 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at MD Allegany Cumberland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Cumberland Street 21502 or Iteme 23e USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 le marked other than "naturel", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Magee Rebecca (McClausand) Magee ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12912 Gramlich Road LaVale MD 2 permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Ie m any injury or other treum once. son MD 21502 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 7/8/2004 Cresaptown MD A □ Donation 5 □ Other (Specify) 22. Nam Scarbein Füneral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UROSEPSIS DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown <u>ALZHEIMERS DEMENTIA, PARKINSONS</u> Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2[] No 1 Yes 2 💢 No 1 Tyes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054411 JULY 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CALKINS,

31. Date filed (Month, Day, Year)

BEVERLY M.

1 3 2004

32. Registrar's Signature

M.D., 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28 2004 7:40P Frances Belle Miglio June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Braddock Heights Frederick Vindobona Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Yrs. Director 220-10-9458 March 9 1917 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature" any injury or other traumatic excessions. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Completed by Funeral Director 1X Yes 2 No MD Brunswick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 USA 619 6th Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 1 Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry C. Kesler Hallie Davis ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 6th Avenue, Brunswick, MD 21716 Frank A. Miglio, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Mary's Cemetery 7/1/2004 Petersville, MD * 4 ☐ Donation 5 ☐ Other (Specify) barbara A. Williams, Owner 22. Name and Address of Facility
John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final Pnysician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage of Injury) Due to (or as a consequence of) Examine as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical nse IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ţō Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by EREBRONASCHUME ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To lhis After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident by the f within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1, 2004 016675 Raver 30. Name and address of person who comple ed use of death (Item 23a) (Type, Print) WAYne 610 Ninth Avenue, Brunswick, MD 21716 31. Date filed (Month, Day, Year) 32. Registrar's Signature State warks! Registrar 2004

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			1 - For State Registrar	State of Marylar		rtificate of			Reg. Ng.	. 22120
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
	Physicia		NICOLA Par	/ MP	RCHES	E . T	Sa.	JUNE	Day 200	4 1:25 PM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Dea	th	4c. County of	Death
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	Funeral		5. Social Security Number 6. Sex	M 2DE	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	n 9. (, Year)	Birthplace (State or Foreign Country)
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	yland now		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Charles		LaPlata	l				1X□Yes 2□No
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	ath w	Funeral Director	108 Quailwood Pky.			20646	F 0:0.1	2	United S	
	er de Items ner n	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in l Armed Forces?		Was Decedent of I If Yes, specify Cub	rispanic Origin? (S lan, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	Black,	American Indian, White, etc.
39	urs aft	by F	3 ₩ Widowed 4 Divorced	1 V Yes 2 No If Yes, Give Year or Dates: 195	§-	1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
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2	filed w Hygier other tl		12 17. Father's Name (First, Middle, Last)		⊥Rea	ltor	18 Mother's Na	me (First, Middle,		tate
and	d be f antal to sed of	Be c	Nicola Marchese,	Sr					ia Manili	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "netural", or items 23e or 28a-1 show armatic event, the Marical Examiner mast be publised at	ဥ	19a. Informant's Name/Relationship (Ty)		19b. Maili	ng Address (Street			r, City or Town, Sta	
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ore,	es 1 ar of Hea of Hea fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, crea	osition (Name of matory or other pla	ісе)	Date	20c. Location - Cit	y or Town, State
Ë	Pages ment of t ent: If ite ury or o		'4 □ Donation 5 □ Other (Specify)		inity M	lemorial	Gdns. 07.	-02-2004_	Waldorf,	Maryland
Baltimore,	permit. Pages Department of Importent: If i any injury or ones		21. Signature of Funeral Service/License	MOIDSI	11.	2. Name and Addr untt Fune	Long Long	1		
	70 F * 04		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	eations that caused the dos	p Do not on	0. Box 1	56, Wald	lorf, MD	20604-015	Approximate
			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	itii. Donot en	ter the mode of dy	ing, such as cardia	ic or respiratory ar	1031,	Interval Between Onset and Death
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Box 68	certiff nding Ise as	//We	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregi		_			23d. Date of	of delivery
	death cerlifical e attending phy ed for use as th	clar	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	;y 		Month	Day Year
P.O.	that the de led by the a detached f	Physician/Medi	9 Unknown	9□ Unknown						
	The law requires that the ate has been signed by th page 2 should be detache	by F	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	ınderlying cause gi	ven in Part I.	_		ite to the cause of death? ☐ Probably 4 ☐ Unknown
ord	requir een s hould	Completed						1 🗆 Y		
3ec	hasb pe2s	mple						24a. Was autop		re autopsy findings available or to completion of cause of th?
alF			25. Was case referred to medical				00 Disease D	1 ☐ Yes	2,25No 1□	Yes 2 No
Ξ	Physiclen: r this certific ral director,	To Be	avaminar?	lospital: 1 Inpatient 2[☐ ER/Outpatie	nt 3 DOA Ot	har	eath <i>(Check only o</i> Home 5 ☐ Resid	dence 6 Other	(Specify)
of	g Phys er this eraf dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju		-	now injury occurred	
ion	Attending I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(World, Bay 7 day)	mjary]Yes 2 □No			
Division of Vital Records,	ter de irecto	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (5 City or Tox		or Rural Route Number,
Ω	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune		29a. Certifier 1 Certifying Phys	sician: To the best of my kr	anuladaa daa	th annumed at the t	imo, data and plac	o and due to the	nauso(s) and mann	er as stated
	ne Hospitel or Attendin 24 hours after death. ne Funerel Director: A	Medical		ner: On the basis of examinand manner stated.						
	To the Hos within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier		· · · · · · · · · · · · · · · · · · ·	29c. Licen	se number		29d. Date signed (/	Month, Day, Year)
			Jara L,	Mo		1000	00286		JUNE 2	8 2004
1	0		30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type	, Print)	M 3. M	- m - n - n -	1-1100000	ND 21287
1	OB IDS		31. Date filed (Month, Day, Year)	32 Phietrar's Sign	nature		IH WULTES	SIMULT DH	timore,	110 21201
	Sta Regist		JUL 0 1 20		B. A.	posts				

			1 - For State Registrar	State o	f Mary	land / Dep <i>Ce</i>	artmen <i>rtificat</i>				/lental H	lygien		22121
1	Physici /Medic		Decedent's Name (First, Middle, La Ritchie Alexande	,							2. Date of I Month June 2	Death Da	Also and and and and and and and and and and	3. Time of Death 11:30 P ^M
	Examir		4a. Facility Name (If not institution, given Anne Arundel Med	e street and nur			4b. City,		Location o	of Death		40	nne Aru	ith
-	Funeral		5. Social Security Number 6. 3	Sex		yrs. last birthday)	If Under	1 Year	If Under		8. Date of E	Birth	Q Rin	thplace (State or Foreign ountry)
	Director		578-07-2889 Usual Residence of Decedent	1 ⊠ M 2□F	87	Yrs.	Months	Days	Hours	Min.	Nov,	0ay, Year 3/191	6 Wasi	hington D.C.
	build be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itams 23a or 28a-f show atte event, I're Medical Examitive intellier at	tor	10a. State 10b. County Maryland Anne Ar	undel		c. City, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 X No
	vith the	Dire	10e. Street and Number			•	10f. Zip						tizen of What Co	•
	18 238	era	525 Tayman Drive	12. Was Dece	dont Fund	in 11 C 42	2140			-:-0./0-			ted Sta	
36	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event. If a Madical Examiner must be ruillied at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Fo	ces? 2∭No e		was Deced If Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or it Rican, etc.)	No-	14. Race - Ame Black, Whit Specify: Wh	
15-00	n 72 hou "natura	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece (Give	dent's Usua kind of wor DO NOT us	Il Occupa	ition furing most	t of work	ing	16b. K	and of Business	/Industry
212	d withi giene. er than	mo:	Elementary/Secondary (0-12)	College (1 4	-4or 5+)		ic Rel					Hear	vy Equi	pm en t
Maryland 21215-0036	uld be file fental Hy rked othe	To Be C	17. Father's Name (First, Middle, Last William Park)							e (First, Midd. Ritch		Sumame)	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Joanne K. Beck /		r	19b. Mailii 111 V	ng Address	(Street a	nd Numbe rkway	r or Rura An	al Route Num	ber, City o	or Town, State, 2	Zip Code) 21403
altimore,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20 State	b. Place of Dispo cemetery, cree	sition (Nan	ne of ther place	a)	[Date	20c. L	ocation - City or	Town, State
ii.	permit. Pa Departmer Important any injury		* 4 □ Donation 5 □ Other (Special 21. Signature of Fundral Service Cice	A-4	La	akemont 1	Mem. (-		lle, Marylan
ñ	Der Imp		Minh	Kh_						2011				al Home, Inc is MD21401
8760,	/Medical Examiner sthe purisition and street sthe purisition and street	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any lasting in miss flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a con	sequence of):	اءطال)ruc	tive	F	2/,	nary	Disease	Approximate Interval Between Onset and Death
O. Box 68	al the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outo 1 ☐ Live bi 4 ☐ Pregna 9 ☐ Unkno	rth 2 □ F int at time	etal death 3	Ectopic pre						23d. Date of deli Month	ivery Day Year
ecords, P.	es that igned b be deta	by	Part II. Other significant conditions of	ontributing to de	ath but not	resulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did			the cause of death?
r		Completed									24a. Wa auto perf 1 ☐ Yes	s an opsy formed? 2 Z No		topsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🔀.				Other		of Death	(Check only	one)		The state of the s
on of	ding Phys h. After this funeral di	tlon; To	1 Yes 2 No 27. Manner of eath Natural 5 Pending investigation	28a. Date o		2 ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 Nul	2	me 5 Res 28d. Describe		3 □ Other (Spec y occurred	ify)
DIVISION	al or Attanding P s after death. Il Diractor: After i d in by the funers	ertification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place	of Injury - A g, etc. (Sp	At home, farm, streecify)					28f. Location City or To	(Street and own, State	d Number or Ru)	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edical C	29a. Certifier 1 Sertifying Ph (Check only one) Medical Exam	ysicien: To the hainer: On the baand mann	sis of exa <i>r</i> r	knowledge, death nination and/or inv	occurred a restigation,	it the time in my opi	e, date and nion, death	place, a	and due to the ed at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		40		29c.	License	number	8	7	29d. Date	e signed (Month	Day, Year)
			30. Name and address of person who	completed cause	of death (Item 23a) (Type, i	Print)	1	1 h	1	c (0	123/	
Ì	Sta Registra		31. Date filed Month, Day, Year) JUN 2 8 2	004 32.	gistrar's Si	gnature)rui	ode	1 1	led	1 cal		en ter	

			For State Registrar	State of M	aryland		artmer rtificat			and M		giene 1eg. No. 2	004	221	22
7 (K)	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	Dav	Year		Death
	/Media	cal	Gayle May Reece	- track and aumbar			4b Cib	Town or	Location o	of Death	June	29 4c Co	2004 unty of Death	1625	
	Examir	ier	4a. Facility Name (If not institution, give Anne Arundel Medi				- "	napol		n Death			e Arun		
	Funeral	çê;x	Social Security Number 6. S	9x 7. Ag	ge (In yrs. las	st birthday)	If Unde	1 Year	If Under		8. Date of Birth	2		nplace (State or untry)	Foreign
Specifica.	Director		212-62-5945	□ M 2 🗗 F	53	Yrs.	Months	Days	Hours	Min.	Jan. 3	0, 19	51 Ma	ryland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				 			10d. Inside City	/ Limits
	Maryli 1 sho ied a	ō	Maryland Anne A	rundel	An	napol	is							1 🗌 Yes	2 N o
	r 28e-	rec	10e. Street and Number			шарог	10f. Zij	Code				10g. Citizer	of What Co	untry?	
	th with	by Funeral Director	1330 Bay Head Roa	d			2	1401				Unit	ed Sta	tes	
	ems er m	ner	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Dece If Yes, spe	dent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	s afte	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 🗌 Yes	2 1 0	Specify:			Sp	ecity: wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show ta Medical Evariater must be rodified at	edt	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupa	ition			16b. Kind	of Business/l		
215	hin 73	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de <i>completed)</i> College (1-4or	5+)	life.	DO NOT L	rk done d se retired)	luring most)	t of workii	ng				
	filed wit Hygiene ether the	Con		2			Nur						alth c	are	
pu	be file	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		mame)		
2	should be and Mental in marked o	ပ္	Elmer Schabdach 19a. Informant's Name/Relationship (7)			19h Mailir	na Addres	(Street a			lehard I Route Numbe		own State Z	(in Code)	
Maryland	ith an		Gene Reece/ husba				•	,			apolis,			,,	
ē,	s 1 ar if Hea item other		20a. Method of Disposition		200	ce of Dispo	sition /Na	ne of			ate		ion - City or	Town, State	
E	Page nent o int: If		1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			imore				-	3, 2004			*	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event, it a Mudical Examination must be routined at once.		21. Signature of Funeral Service Licen	Email	'n				s of Facilit					ral Home , MD 21	
	Physician /Medical Examiner	iner	23a. Part. Enter the disease, or commodisher cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a	s a conseque	Ince of):	eng V	7	H)p		00100		Approximate Interval Betw Onset and D	reen
. Box 68760,	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 5 No	c	2 Fetal d	cy leath 3[⊒Ectopic μ					230	l. Date of deli Month		ear
P.0	ac ac	Phys	9 Unknown		L	the street of			n in Dad I		220 Did to	bacco uso	abatributa ta	the cause of de	ath?
ds,	Se Se Se	by	Part II. Other significant conditions o	ontributing to death	but not result	ang m me u	nderlying	ause give	m m ran i.	•	1 🗆 Y				nknown
ecords,	requ	etec					-				24a. Was			topsy findings a	vailable
$\boldsymbol{\alpha}$	The far ate has page 2	Completed									autop perfor	med2 2 No	prior to death? 1 ☐ Yes	completion of ca	use of
V.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 14 Inpat	iont 2 🗆 E	R/Outpatie	nt 3 D	Othe	3.00		ne 5 ☐ Resid		Other (Spec	oifu)	
of		n: To	27. Marner of Death	28a. Date of Inj	ury 2	28b. Time o		28c. Injury Work			28d. Describe h			ary)	
ion	Attending F r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	1	ay rear/	Injury	М		r Yes 2 ∐i	No					
Division of Vital	et or Atte s after de it Directo id in by th	Certification;	3 Suicide 6 Could not be determined	286. Place of It	njury - At hom tc. <i>(Specify)</i>	ne, farm, st	reet, facto	y, office		1	28f. Location (S City or Tow		lumber or Ru	iral Route Numb	eer,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C		ysician: To the bes	of examination										
	To th withir To th	Me	29b. Signature and title of centifier.	moder	MO)		c. Liceose	number 3	145		29d. Date s	igned (Month	O 2	004
			30. Name and address of person who	JI GIN	60	0/5	Print)	1-14	17)	6	An	nepi	1/2/	(Ju)	
	St Regist	ate trar	31. Date filed (Month, Day, Year) JU[= 1	2004 32. Has	trar's Signatu	A .	1.	,				•			

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				State	UI IVIA	i yianu /		ificate of		мена пу	glerie Reg. NoΩ	. 22122
			1. Decedent's Name (First, Mic	idle, Last)						2. Date of Dec	eth Day Ye	3. Time of Death
	Physici /Medic		Jean Elizabeth	Richards						JUNE	21 200	
1	Examin		4a Fecility Name (If not institut	ion, give street and n	u <i>mber)</i>	-			4b. City, Town, o	Location of Death		
-/-			Futurecare Che	sapeake					Arnold		Anne Ar	und e1
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last t	oirthday)	If Under 1 Yea Months Days			h 9.	Birthplace (State or Foreign Country)
	Director		169-22-4224 Usual Residence of Decedent	1□M 2X F	75		Yrs.	Months Day:	S Hours Mir	May 1,	1929 Per	nnsylvania
	show	_	10a. State 10b. Coun			10c. City, To	wn or Loca	ition	·			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	Sa-f	5	Maryland Anne	Arundel		Arnol	d					
	it t	늅	10e. Street end Number					10f. Zip Code			10g. Citizen of What	-
	ath v	a	1284 Circle Dr					21012			United Sta	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heatth and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2XX Ma 3 □ Widowed 4 □ Divorce	arried 12. Was De Armed F 1 ☐ Yes If Yes, G Year or	_ 2 ∑X No aive	ver in U,S.		as Decedent of Yes, specify Cu ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Specify Yes or No- rto Rican, etc.)	Specify: \	merican Indian, White, etc. White
5-0	72 hk	ह	15. Deced	ent's Education hest grade completed	n	16	a. Decede	nt's Usual Occu	pation	orkina	16b. Kind of Busine	ess/Industry
21	thin thin	ם	Elementary/Secondary (0-12		/ (1-4or 5+	+)	life. Do	NOT use retir	e during most of weed)	si king		
2	filed withi Hygiene. other then	్ర	12			E	xecut	ive Sec	retary		Insurance	3
nd	al Hy	Be (17. Father's Name (First, Middl	e, Last)							Maiden Sumame)	
la	uld b Ment rked rice	٥	Charles H. Con	stantine					Matilda	A. Weid	man	
Maryland	i and 2 should be Health and Mental em 27 is marked o other traumatic eve		19a. Informant's Name/Relatio								er, City or Town, Stat	
	and afth afth 27 is		James Richards	/ Husband	1			ircle D		rnold, Ma	aryland 2	1012
ē	of He item othe		20a. Method of Disposition		_	20b. Place	of Disposi	tion (Name of tory or other pl	ace)	Date	20c. Location - City	or Town, State
Ĕ	Page ent c nt: if ry or		1 ☐ Burial 2 XX Cremation 4 ☐ Donation 5 ☐ Other	ı 3 ∐Removal from <i>(Specify)</i>	n State			Cremato		6/23/04	Baltimore	, Maryland
Baltimore,	permit. Pages I Department of H important: If ite any injury or ot		21. Signature of Funeral Service	5) icens			22. 1	Name and Add	ress of Facility J	ohn M. T	aylor Fune	eral Home, Inc. Lis, MD 21401
		\dashv	23a. Part1. Enter the effsease, shock, or heart failure. Li	or complications that	caused t	he death Do					•	Approximate
	Physician /Medical Examiner	miner	Immediate Cause (Final disease or condition resulting in death)	a. <i>CE</i>	C	Due to (or as a	a conseque	ence of):	DISEAS	E		
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use es the burial-transit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d		oue to (or as a						
Вох	eath cer attendin I for use	Physician/M										1
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P.0	that the de led by the a deteched t	됩								1 🗆 1	Yes 2□ No 3□	Probably 4 Michael
Records,	v requires that been signed should be del	ted by								24a. Was	an autopsy 24	b. Were autopsy findings available prior to
360	e law re has be ge 2 sh	Completed						4			1011 - Name (1-4a)	completion of cause of death?
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Vital	cian sertifi ector	å	25. Was case referred to medic examiner?	1				To.		ath Check only o	ne)	
of	Physician: this certific	٤	1 Yes 2 No		Inpatien	-		3LI DOA			lence 6 Other (S	(ipecify)
L C	ng F	<u></u>	27. Manner of Death 1 ☐ Matural 5 ☐ Pend		of Injury nth, Day	Year) 28b.	Time of Injury	28c. Inju		28d. Describe h	ow injury occurred	
Sic	Attending or death. ector: After by the fune	cat	2 ☐ Accident Inves	d not be]Yes 2□No	00/ 1 /6		0.10.11.1
Division	or Attendi efter death. Director: A d in by the f	Certification:	4 Homicide deter	rmined 200. Plac	e of Injur ding, etc.	y - At home, (Specify)	tarm, stree	t, factory, office	1	City or Tow		Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1 Certify	ring Physician: To the al Examiner: On the b	e best of	my knowledg	ge, death o	ccurred at the t	ime, date and plac	e, and due to the o	cause(s) and manner	r as stated.
	the H hin 24 the F plete	8	one)	and mar	nner state							
	Vith To 1	Σ	29b. Signature and title of certif	ier					se number	1	29d. Date signed (M	
			monig	, Mis				1)5	7531		June 21	1,2004
		t	30. Name and address of pess	n who completed cau	ise of dea	ath (Item 23a	(Type, Pr	int)	1531		June 21	/
	<u> </u>		Mohit Neg	5 8601	Vete	vans	Hu	y M	1 Wersul	lle, N	W 21108	<u> </u>
	* Sta	е	31. Date filed (Month, Day, Yang		Registrar	's Signature		11				
	Registra	ir	JUN	2 4 2004	The state of	ear 1	K A	mark)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 4,2004 **Physician** 9:00A M MARY JACQUELINE ROY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES SCUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) FEB • 15 • 1929 MISSOURI 5. Social Security Number 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 □ M 2 1 F Yrs. 75 Director 314-26-3010 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1X Yes 2 □ No LA PLATA MARYLAND CHARLES 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20646 3017 WILDFLOWER DRIVE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER N.C.PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should ba 1 1 and Mental F GRACE SHAW MIRVEL DUTCH ASHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny injury or other tre once. 3017 WILDFLOWER DR. LA PLATA, MARYLAND 20646 GEORGE ROY-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEMETERY 7-9-04 CHELTENHAM, MARYLAND ^¹ 4 □ Donation 5 □ Other (Specify) M00479 21. Signature of Euneral Service Licenses 22. Name and Address of Facility
RAYMOND FUNERAL RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for usa as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 10SCLEROTIC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 2 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To tha within 2 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Old Line 12010 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

		4	1 - For State Registrar	State of M	aryland / Depa	artment of F			iene	22.125
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary L	ou		Robin	con	2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give s Morningside House	treet and number)		4b. City, Town, or Waldo:	r Location of Dea		4c. County of D Char	
	Funeral Director		5. Social Security Number 238-30-7047 Usual Residence of Decedent	M 2 TF 7. Ag	ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. 1926 No	Birthplace (State or Foreign Country) orth Carolina
	Maryland -1 show fied at	tor	10a. State 10b. County Maryland Charles		10c. City, Town or Lo	cation Walde	orf			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23e or 28e st be noti	al Direc	10e. Street and Number 70 Village Stre	et		10f. Zip Code	20602	1	0g. Citizen of What U.S.	Country?
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event. The Medical Evantral russ be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
21215-0036	vithin 72 ho ne. han "natul na Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or !	(Give life.	lent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. Kind of Busine	
9	filed withi Hygiene. other than ent. The M		17. Father's Name (First, Middle, Last)	22	Buds	et	Analy 18. Mother's Na	rst ame (First, Middle, I	U.S. Gov Maiden Sumame)	vernment_
lan	2 should be and Mental Is marked o sumatic eve	To Be	Eugene Rankin		Duva11		I	na	Houcl	k
Maryland	2 should be and Mental Is marked or raumatic even	2	19a. Informant's Name/Relationship (Ty) Joan Early (Day					Rural Route Number		ne, MD 20613
re, I	s 1 and 2 I Health Item 27 other tr		20a. Mathod of Disposition		20b. Place of Dispo			Date	20c. Location - City	
imo	Pages nent of I ent: If its ury or o		1 Burial 2 Cremation 3 □R 1 Donation 5 □ Other (Specify)	emoval from State	Cedar Hil			y 1,	Suitland,	Maryland
Baltimore,	permit. Pages 1 a Department of Hea Importent: If item any injury or othe		21. Signature of Funeral Services License	Dle n	00,52	. Name and Address		ee Funera ia Ferry		Inc. on, MD 20735
	Fnysician /Medical	1 0	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each li	RDIOM.		15079	ac or respiratory arr	est,	Approximate Interval Between Onset and Death 6 MTHS
	Examiner		Sequentially list conditions		a consequence of);					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
8760,	ate be executed hysician and the burial-transit		resulting in death) Last		a consequence of):					
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
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Vital Records,	The law requir ate has been s page 2 should	Completed	AORTIC	STE	VOSIS			24a. Was a autops perforr	y prior ged? death	autopsy findings available to completion of cause of 1?
/ital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		0#		eath (Check only on		Esperien
of	ding Phys n. After this funeral di	Certification: To	1 Yes 25No 11 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time of	28c. Injun Worl	4 🗆 Nursing	Home 5 Reside		pecify) V N C
Division	l or Atten after deatl Director: I in by the	ertific	3 Suicide 6 Could not be 4 Homicide determined		jury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Check only one) 2 Medical Examin	ician: To the best ler: On the basis o and manner st	of my knowledge, death of examination and/or in- ated.	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner ate and place, and c	as stated. due to the cause(s)
	To th Vithir To th	Me	29b. Signature and title of certifier	w		29c. Licenso	2 8 2		Od. Date signed (Mo	
(30. Name and address of person who co	mpleted cause of o	death (Item 23a) (Type,		- 0		JUNEZ	19,2004.
1	B15		Nelson V. Benjer	s,MD 6B]	[ndustrial		e Prest	on Sq. #2	Waldorf,	Maryland
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 2 20		rar's Signature	cooks				

		1 - For State Registrar	State of Maryland /	Depar		alth and N	∕lental Hygi	ene g. No 2004	22126
Physic /Med Exami	ical	4a. Facility Name (If not institution, give	INGE RICHARDSON		4b. City, Town, or Lo		2. Date of Death Month JULY	3 2004 4c. County of Deatt	
Funeral Director		CORSICA HILLS NU. 5. Social Security Number 6. Se 229-03-2451				f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB. 14	QUEEN AN 9. Birth Co Co VII	INE'S nplace (State or Foreign Intry) RGINIA
the Maryland 28a-f show	Director	MD 10a. State 10b. County QUEEN AT	NNE S		TREVILLE				10d. Inside City Limits 1 X Yes 2 □ No
within 72 hours after death with the Maryland within 72 hours after death with the Maryland ene. than "netural, or Items 23s or 28s-f show its Medical Exertine from the straight at	by Funeral	205 ARMSTRONG A 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	VENUE 12. Was Decedent Ever in U.S. Armed Forces? 1		21617 S Decedent of Hisp es, specify Cuban, Yes 2 X No	anic Origin? (Sp Mexican, Puerto Specify:		g. Citizen of What Cou USA 14. Race - Amer Black, White Specify: W	ican Indian,
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VICE Y COLOR 10 2 Should be file 11 and Mental Hy 27 is marked oth 1 reumatic evant	To Be	DABNEY RICHARD 19a. Informant's Name/Relationship (Ty		b. Mailing		MILDRI	e (First, Middle, M ED PAULET		in Code)
perfullible; Index yields ATA 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other treumatic event, to Medical Exacutar Intest to Inditional angre.		MYRON F. RICHARDS 20a. Method of Disposition 1 Maurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature Funeral Service Liosus	ON/ SON 4 20b. Place of cemete EVERGR	of Disposition, cremain CEEN (CEEN CEEN CEEL)	On (Name of tory or other place) CEMETERY	DRIVE, () 7-7-2	Date 2 2004 E NEWNAM	ILE, MD 216 Oc. Location - City or To VERGREEN, FUNERAL HO	17 own, State VA
bhysician be executed / Medical Examiner as the burial-fransit	dical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it is a failure of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	of):					Approximate Interval Between Onset and Death
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ttending Phys death. ctor: After this	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined		Time of Injury	3 DOA Other: 28c. Injury at Work? M 1 Yes	4 Nursing Ho	28d. De <i>s</i> cribe how	et and Number or Run	
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Ce	29a. Certifier (Check only one) Certifying Physical Examination	cician: To the best of my knowledge er: On the basis of examination an and manner stated.	e, death or nd/or inves	ccurred at the time, of tigation, in my opinion	date and place, a	and due to the cau ed at the time, date	se(s) and manner as s a and place, and due to	tated. o the cause(s)
To the within To the comp	Me	29b. Signature and title of cartifier	m			36		Date signed (Month,	
OVP Sta Registr		30. Name and address of person who co	mpleted cause of death (Item 23a) 2 2 Registrar's Signature	(Type, Pri	rub D-1	ve U	Life, or	9 2/61	5

			1- State of Maryland / Department of Health a Certificate of Death	and Mental H	ygiene	4 22127
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of D Month	eath Day	3. Time of Death
	/Media	al	Rosa Hall Randall	June	27,2004	9:10 A ^M
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Frederick Memorial Hospital Frederick	of Death	4c. County o	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		Frede	9. Birthplace (State or Foreign Country)
	Director		320-05-6443 1□ M 2♥F 93 Yrs. Months Days Hours	Min. (Month, D May 2:	1, 1911	Illinois
	and wo		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary -1 sho	ţ	MD Frederick Frederick			1 ☐ Yes 2X No
	or 28e	lirec	10e. Street and Number 10f. Zip Code	·	10g. Citizen of W	fhat Country?
	ath wi	rai	7407 Willow Road 21702		J	JSA
	er des	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent of Hispanic Original Mexican 12. Was Decedent of Hispanic Original Mexican 13. Was Decedent of Hispanic Original Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)		e - American Indian, k, White, etc.
920	urs af	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		Specify:	White
Maryland 21215-0036	72 hours after death with the Maryland Insturel', or Items 23e or 28e-f show disal Evaniliser must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most	of working	16b. Kind of Bus	
121	within ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	o. woming		
0	Hygie Hygie other i	မ င	4 Office Manager 17. Father's Name (First, Middle, Last) 18. Mother	r's Name (First, Middle	Health e. Maiden Sumame	
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lary	and N ls ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	r or Rural Route Numi	per, City or Town, S	State, Zip Code)
Z,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any figury or other traumatic event, Ite Madical Evaratives must be notified at ance.		Elsie McKenney - Daughter 8919 Cleasonville			
Baltimore,	ages 1 nt of H : If ite		20a. Method of Disposition 1 MBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other place) Politics Morror of Company (Name of cemetary), crematory or other place)	Date		City or Town, State
Ħ	artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility		Millersv	
B	Depa Impo eny Ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility M9.70	Harpers F	bencer Fu erry. W	neral Home 25425
			23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respiratory	arrest,	Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	Diver		Onset and Death
	/Medical Examiner		Due to (or as a consequency of):			
		er	Sequentially list conditions, b			9 Cars
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Box 6	that the death certific ed by the attending pl detached for use as t	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d Date	of delivery
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	ding P. h. After t	lon;	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?	28d. Describe	how injury occurred	
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<u>S</u>	al or A s after I Dire	Certification;	4 Homicide determined building, etc. (Specify)	City or To	wn, State)	or ribrar ribble Number,
	To the Hospital or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and properties of examination and/or investigation, in my opinion, death and manner stated.	I place, and due to the n occurred at the time,	cause(s) and mann date and place, an	ner as stated. Ind due to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed ((Month, Day, Year)
)			MDD16428		6/2	7/04
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	9		Casper E. Cline, III - 300 West 9th Street - Fred	erick, MD	21701	-/
	Sta Registr		31. Date filed (Month, Day (Mar) 2 9 (11) 32. Registrar's Signature			

		For State Amend Item 29 Registrar 1. Decedent's Name (First, Middle, Last)		- 00	Timeate of L		2. Date of D		3. Time of Death
Physicia /Medic		JAMES HAROLD	SCHERER	, JR.			JUNE	30 200	
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or			4c. County of D	
		Union Hospital 5. Social Security Number 6. Sex	7. Age (In v	rs. last birthday)	Elkton	If Under 24 Hrs.	8. Date of Bi	Ceci	L Birthplace (State or Foreign
Funeral Director		163-32-9934 ¹⁰³	M 2□F 6		Months Days	Hours Min.	8. Date of Bi (Month, D Aug 2	ay, Year) 6 1939 P	Country) ennsylvania
yland		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
within 72 hours after death with the Maryland ene. Then "naturel", or flems 23e or 28e-f ehow re Modical Examirer resit terriofffiad af	Director	MD Cecil	E	arlevi				40-0004145	1 ☐ Yes 2 🔯 No
a or 2 Lean	Dir	10e. Street and Number			10f. Zip Code	,		10g. Citizen of What	Country?
TIS 23	Funeral	67 Midway Dr.	2. Was Decedent Ever in	n U.S. 13.	21919 Was Decedent of His If Yes, specify Cubar		pecify Yes or N	U.S.A. o- 14. Race - A	merican Indian,
if of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28e-f ehow or other traumatic event, the Madical Examinar most be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No 1 If Yes, Give Year or Dates: _ 1	963	1 ☐ Yes 2 🛣 No	Specify:	Hican, etc.)	Specify:	/hite, etc. White
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Hygiene. other then ent, ire M	Co	12 17. Father's Name (First, Middle, Last)		necei	. Service			a, Maiden Sumame)	er Service
Mental I	To Be	James Harold S	cherer, Sr	•				Diffinder	fer
and Men is marke raumatic		19a. Informant's Name/Relationship (Type Karen Scherer	oe, Print) (wife)		ng Address (Street a			per, City or Town, Stat	
Health tem 27 other tr		20a. Method of Disposition		p. Place of Disp	osition (Name of		Date	Le, MD. 2	
nent of I ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	matory`or other place cemation		/04	Smyrna,	
Department of important: If it eny injury or conce.	İ	21. Signature Supportal Service Doenn		2	2. Name and Addres Balena F	is of Facility Uneral	Home o		n L Schaech
100		23a Part Enter the disease, or complishock, or heart failure. List only on	cations that caused the d						Approximate Interval Between
hysician and hysician street is the burial-transit	Examiner	Immediate Cause (Fihal disease or condition resulting in death) Sequentially list conditions, if any, leading to ammodiate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	Ocurdia	(1nt	archi	, L.	
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n signed by the atte ild be detached for	d by Ph	Part II. Other significant conditions con Dichetes M	etributing to death but not	resulting in the t	underlying cause give	en in Part I.			e to the cause of death? Probably 4 Donknown
nas been s e 2 should	Completed by	Peripheral 1	resculer	Diseco	و		24a. Was		autopsy findings available to completion of cause of
certificate has t rector, page 2 s		1+2 per ten 510 25. Was case referred to medical	n Chro	11c 065	itricture	Pulmoner	1 Yes	2/2/No 101	/es 2□No
	To Be	evaminer?	lospital: 1 Inpatient 2	2 ☐€R/Outpatie	nt 3 DOA Othe	26. Place of Deal er: 4 Mursing H		one) idence 6 🗆 Other (5	Specify)
n. After th funerai		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		of 28c. Injury Work			how injury occurred	,,
after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, st ecify)	reet, factory, office			(Street and Number or wm. State)	Rural Route Number,
ours neral fille	edical C		sician: To the best of my ner: On the basis of exam and manner stated.						
24 h Fur stely	Me	29b. Signature and title of certifler	2		^{29c. License} D5208	number		29d. Date signed (M	onth, Day, Year)
within 24 hours after deat! To the Funeral Director: completely filled in by the		× 1/4 / 0 / 1	11		0.0200	• •			
within 24 h To the Fur		> Mulily	Luce Ir	m	m-4	2281		June 3	0, 2004
To the Hospital or within 24 hours after To the Funeral Dirth completely filled in I		30. Name and address of person who co	2	Item 23a) (Type	m-4	Bow .	Street nors la	June 3	0, 2004 21

			1 - For Registrar	State of Ma			of Health and I	Mental Hy	giene Reg. No.2 0 0 4	22129
			Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of Death
	Physici /Medi Examir	cal	Billie 4a. Facility Name (If not institution,		anziale	4b. City, Toy	wn, or Location of Death	June	Day Year 200 4c. County of Dea	4 9:40 PM
	Funeral		NOSTH AC	under Ho	Spital (In yrs. last birtho	day) If Under 1 Y	Bunie Gear of Under 24 Hrs.	8 Date of Birth	Anner	tholace (State or Foreign
5	Director		236-48-8811 Usuel Residence of Decedent	1□M 2XIF	74 Yr	S.	ays Hours Min.	Nov. 5,	r, Year) C	t Virginia
	72 hours after death with the Maryland Insturel, or itema 23a or 28a-1 show Oral Examiner must be multified at	tor	10a. State 10b. County Maryland Prince	Georges	10c. City, Town of Bowie	or Location				10d. Inside City Limits 1 X Yes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip Co	de		10g. Citizen of What C	ountry?
	23a o	D	12016 Tulip Grov	e Drive		2071	5		U.S.A.	,
	deat	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
39	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 le marked other than "natural", or Itema 23a or 28a-1 ehov other traumatic event, the Medical Examinar in ust be rutified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced			1 Yes 3		o nican, etc.)	Black, Whi	
9	2 hou	ted	15. Decedent's	Education	16a. D	ecedent's Usual O	ccupation		16b. Kind of Business	Andustry
21215-0036	within 7 ene. than "n he Wed	nple	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or 5+			one during most of won etired)	king	0 11-	
	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, the M		17 Fother's Name (Sint Middle)	2	поі	nemaker			Own Ho	me
Maryland	ould be fi Mental P arked ot atic ever	Be	17. Father's Name (First, Middle, L.					_	Maiden Sumame)	
Z	2 should and Men ie marke sumatic	2	James Wesley 19a. Informant's Name/Relationshi	Anderson		lailing Address /St	Calus reet and Number or Ru	Otto		
	1 and 2 : Health ar tem 27 to other trau		Alfred Stanziale				Grove Driv			20715
Baltimore,	les 1 and of Health If Item 27 or other to		20a. Method of Disposition 1 ABurial 2 Cremation	3 Removal from State	cemetery,	isposition (Name o	place)		20c. Location - City or	Town, State
Ë	. Pages tment of I tant: If Its jury or o		`4 □Donation 5 □Other (Spe	ecify)	Maryland	Veterar Cemetery		2004	heltenham,	Maryland
Ball	permit. Pages Department of Important: If If any injury or c		21. Signature of Funeral Service Li	censee			ddress of Facility Ro			
	40240	\vdash	23a. Part1. Enter the disease, or c	omplications that caused the			napolis Roa			20715
	Physician /Medical		shock, or heart failure. List o fmmediate Cause (Final disease or condition resulting in death)	a. Sep 5	consequence of):		dying, such as cardiac	or respiratory arr	031,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequence of):					
	outed od ransit	Examiner	Cause (Disease or injury that initiated events	c						
8760,	be executed sician and burial-transit	ical Ex	resulting in death) Last	Due to (or as a	consequence of):					
687	physi s the b			d						
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death	3 DEctopic pregna 5 Other (specify			23d. Date of del Month	rvery Day Year
Records, P.	uires that signed b	by	Part II. Other significant condition Demontor	s contributing to death but	not resulting in th	e underlying cause	given in Part I.		pacco use contribute to	
CO	w requir been s should	lete	Malnutri	tion				24a. Was a		topsy findings available
_	ian: The lav rtificate has tor, page 2:	Completed						autops perforn	y prior to death?	ompletion of cause of
Vital	Phyaician: r this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Deat			
of	Physic runis aral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpa 28b. Time	HOIL 30 DOX	4 Nuising Ho		nce 6 Other (Spec	city)
ion	Attending ir death.	atlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Y	<i>'ear)</i> Injur	у ,	Work? 1 ☐ Yes 2 ☐ No	200. 20001100 110	w injury occurred	
Division	al or Attending P s after death. I Director: Alter t d in by the funera	Certification:	3 Suicide 6 Could no determin		- At home, farm, (Specify)	street, factory, offi	се	28f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of a caminer: On the basis of ea and manner state	camination and/oi	eath occurred at the	e time, date and place, ny opinion, death occurr	and due to the ca red at the time, da	tuse(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	D .	- M1	29c. Lic	ense number	25	9d. Date signed (Month	, Day, Year)
			Messar C	Wills	M III	D	41365		June 30	,2004
			30 Name and address of person w	completed cause of dea	th (Item 23a) (Typ	Print) -1	I Drive,	Gen B	worle, MD.	21061
8	Sta Registr	-	31. Date filed (Month, Day, Year)	32 legistrar's	Signature	harth .				

DHMH 17 Rev 1/2001

Billie

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	Health L)	1 - For State Registrar	State of Mary			ealth and l	_		22120
	Physici /Medio		1. Decedent's Name (First, Middle, Last Wayne Arlan	Scruggs				2. Date of Death Month June 27,	Day Year 2004	3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give 5381 Sands Rd #19 5. Social Security Number 6. Se 428-60-9567	0	yrs. last birthday) Yrs.	4b. City, Town, or Loth If Under 1 Year Months Days	ian			rthplace (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than *naturel', or Items 23a or 28e-f show eny injury or other treumetic event. Ite Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Georgia Walton 10e. Street and Number 946 Navaho Trai. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Thomas 19a. Informant's Name/Relationship (Ty	100 12. Was Decedent Ever Armed Forces? 1 [X] Yes 2 DNo 1 [Yes, Give Year or Dates: 195 Cation to completed) College (1-4or 5+) M. Type, Print) Life Removal from State H	in U.S. 13. 1 52-54 7-59 16a. Deceding in Example 1946 N b. Place of Disported 1940 N b. Place of Disported 1940 N cemetery, cremetery, cremete	Nas Decedent of His Yes, specify Cubar I Yes 2 No Sent's Usual Occupation of work done of Octowers (Street a Vavaho Trassition (Name of natory or other place n Memory 195	spanic Origin? (Sin, Mexican, Puerto Specify: ttion uring most of work ger 18. Mother's Nam Verna and Number or Ru ail, Mona	Decity Yes or No- Decity Yes o	Citizen of What C S.A. 14. Race - Am Black, Wh Specify: D. Kind of Business Utiliti den Sumame) ton ity or Town, State, ia 3065 Location - City on nroe, Geo:	erican Indian, ite, etc. White s/Industry es Zip Code) Town, State rgia
	Fnysician /Medical Examiner	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Acute n	s quence (f):	er the mode of dying	such as cardiac	d, Bowie, or respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 [Ectopic pregnancy Other (specify)			23d. Date of de Month	livery ~ Day Year
	es gu	ρχ	Part J Other significant conditions con	atributing to death but not	resulting in the un	derlying cause giver	n in Part I.	23e. Did tobaco		o the cause of death?
	icien: The law certificate has t rector, page 2 s	e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2	prior to death?	itopsy findings available completion of cause of 2□ No
Division of Vi	hye his	To B	examiner?	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatient 28b. Time of Injury	3 □ DOA Other 28c. Injury a Work?	4 Nursing Ho	h (Check only one) me 5 X Hairban 28d. Describe how in	- 6 ⊠Other (Spe	^{city)} Canp⊱round
Divis	oitel or Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecity)			28f. Location (Street City or Town, St	ate)	
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	fedicai	one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inve	estigation, in my opir	nion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
•	with To Con	Σ	29b. Signature and title of certifier T.C. O Home	von, mb			7632	- 7	Date signed (Monti	, 2004
				knovan, 1	nd 21	12 Dun	DALK	AVE BI	ALTO M	D 21222
	Stat Registra		31. Date filed (Month, Day, Year) JUN 2 9 200	32. Pegistrar's Sig	gnature	and 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -ucille Simmons Month Day 2004 8:20 R Vernice 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oakland Cuppet and weeks (-arre If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Oay, Year) 1 □ M 2 1 F Yrs. 214-07-3118 98 Jan 29.1906Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 No Allegany Flintstone 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA Route 1 21530 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James E. Smith Ella Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hafer Funeral Home-FD 1302 National Hwy, LaVale, MD 21502 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State July 8,2004 cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter & Paul Cem 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD Signature of Funeral Service Doensee 22. Name and Address of Facility Hafer Funeral Service, PA 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 1e, shock, or heart failure. List only one cause on each line. MD Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) inanit month Due to (or as a consequence of): Senile dementia of Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? herosclerutic Vascylor 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ir then "neturel", or iteme 23e or 28e-f eho the Medical Examiner must be notified at

or other traumatic event, permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 2008.

e filed within 72 hours efter d at Hyglene. other then "neturel", or item

altimore, Maryland 21215-0036

Funeral Director

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Completed

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with the Marylend

Examiner Physician/Medical Completed by

ettending physicien and for use es tha buriai-transil deteched has this certificate Be ဥ Certification; efter death. Director: Af

filled

completaly

within 2.

Medical

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospitel 24 hours IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21520 Walter K. Naumann M.D.

29a. Certifier (Check only one) 29b. Signature and title of certifier

BO

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00025754

State

3 Suicide

4 ☐ Homicide

31. Date filed (Month, Day, Year)

82. Registrar's Signature

Accident

DHMH 17 Rev 1/2001

Registrar

MD

			1 - For State Registrar	State of Ma	aryland /		rtment tificate					Reg. N	00	04	22132
	Physici		1. Decedent's Name (First, Middle Huqh	, Last) Clevlano	i.	Sm	ith				2. Date of D Month une 2	eath 25 , Da	200	Year	7:30A M
	/Medio Examir		4a. Facility Name (If not institution				4b. City, 7	Γown, or L	ocation of				c. County		7.50A
		•	Frederick Me	morial Hos	spital		_	deri	ck			F	rede	ericl	c
	Funeral Director		5. Social Security Number 223-24-1782 Usual Residence of Decedent		e (In yrs. last b 86	yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B. (Month, D April	irth lay, Year 1 ,	1918	9. Birthpla Counti Vir	ace (State or Foreign ry) ginia
	yland yland		10a. State 10b. County		10c. City, To									10	d. Inside City Limits
	Ba-fs	Director	Virginia Wythe		Rural	Ret	reat								1 ☐ Yes 2 X No
	ath with the 23a or 2 ual be no	al Dire	P.O. Box 485				10f. Zip 24	368						/hat Counti State	
9800	iges 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mentat Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show if Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Exactive rines by nyuffled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ed 1 X Yes 2 1 If Yes, Give Year or Dates:		lf lf	/as Decedo Yes, speci	ify Cuban,	panic Orig Mexican, Specify:	in? (Spec Puerto R	cify Yes or N lican, etc.)	0-		- America k, White, e Whi	tc.
1215-(within 72 h ene. then "natu ne Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5		(Give k life. D	ent's Usual kind of work O NOT use rmer	k done du	on ring most	of workin	g		Gind of Bu	siness/Indu	ustry
Maryland 21215-0036	2 should be filed and and Mental Hygie is marked other raumatic event, I	To Be Co	17. Father's Name (First, Middle, Grover Cleve	<i>'</i>			I mor	1			(First, Middle Kitts				
	1 and 2 sho Health and I iem 27 is ma		19a. Informant's Name/Relationsl Nina L. Hagy		1	1783	Cold	broo			Route Numb			State, Zip (1770	Code)
Baltimore,	permil. Pages 1 an Depertment of Heal Importent: if Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		20b. Place cemet				ļ ļ	Da				City or Tow	
Ħ	oil. Pa artmer ortent injury		 4 □ Donation 5 □ Other (S_i 21. Signature of Funeral Service 		Plea	sant	Hill Name and	Cem	et. 6,	$\frac{1}{29/2}$	2004 L. Mo	Gr			Virginia
Ba	Depermine Depermine Suny is suny is		Dlin I	Molen	oth						mascus			1, P. <i>E</i>)872	4.
	Physician /Medical Examiner	95	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. PNE Due to (or as	ne. VMOM/ a consequence	A e of): 5B ST					respiratory a		(ASZ	1	Approximate nterval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the buriat-transit	edicai Examiner	Sequentially list conditions, the state of the conditions, and the conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence		- 10					_			
P.O. Box	thet the death certific ted by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		Ectopic pre Other (spe						23d. Date Mon	of delivery	day Year
	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditio	ns contributing to death be	ut not resulting	in the un	derlying ca	use given	in Part I.		ر. ا		_	_	cause of death?
of Vital Records,	n: The law re licate has be rr, page 2 sho	Completed									24a. Was auto perfe 1 Yes		pr de	fior to comp eath?	y findings available oletion of cause of
	Attanding Physician: The tar death. actor: After this certificate ha actor: After director, page 2 by the funeral director, page 2	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin, 2 Accident investig			outpatient Time of Injury		Other: c. Injury a Work?	4 🗆 Nurs	sing Hom- 28	Check only on the second of th	dence			
Division	i Diffic	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		iry - At home, f c. (Specify)	farm, stre	et, factory,	office		28	8f. Location (City or To	Street ar wn, State	nd Numbe	r or Rural F	Route Number,
	Hospitei 24 hours a Funeret stely filled	edicai	29a. Certifier 1 Certifyin (Check only one)	Physician: To the best of examiner: On the basis of and manner sta	examination a	ge, death ind/or inve	occurred a estigation, i	t the time, in my opin	date and ion, death	place, an	d due to the d at the time,	cause(s date and) and man d place, ar	ner as stat	ed. ne cause(s)
•	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	1/	м. D .			License r	umber 7790	6			te signed	(Month, Da	2004
1	Lil			who completed cause of de			,								
	TTI	10	Lalit Verma, M 31. Date filed (Month, Day, Year)	D.,400 W. 7	th Stre		Frede	rick	, MD	217	701				
	Sta Registr	ar	31. Date filed (Month, Day, Year)	28 2004	energy	/-	1	apa	us)						

			1 = For State Registrar	State of M	arylan		artment <i>rtificate</i>			and M		Reg. No	$2 \mathrm{Hz}$		22133
	Dhysisi	-	1. Decedent's Name (First, Middle, La								2. Date of De		X	Year	3. Time of Death
	Physici /Medio		Robe		e	Smrcka					June 24		<u>004</u>		10:20 PMM
	Examin	er	4a. Fecility Name (If not institution, give					Town, or Ai	Location o				County	of Death deric	ck
_			Kline Hospice Ho		in (In vrs.)	ast birthday)	If Under 1		If Under	24 Hrs.	8. Date of Bir (Month, Da Sept.	th			
1	Funeral Director			M 2□F	77	Yrs.	Months	Days	Hours	Min.	Sept.	23.	1920	6 Nev	place (State or Foreign ortry). Vork
			Usual Residence of Decedent												
	nylan how		10a. State 10b. County			, Town or Lo								1	1 ☐ Yes 🎾 No
	Ba-f	Director	Maryland Frederi	LCK	Fr	ederio	_					10.00			
	vith th	Die	10e. Street and Number 6603 Hunter Tr	oil May			10f. Zip (702			-	.S.A	Vhat Cour	itry?
	72 hours after death with the Maryland natural', or items 23s or 28s-f ehow dical Examinations in collised at	Funerai	11. Marital Status	12. Was Decedent	Ever in 11	S 13 \	Was Decede			ain? (So	ecify Yes or No				can Indian,
	fter d	E	1 Never Married 2 Married	Armed Forces	No No		_	_		, Puèrto	ecify Yes or No Rican, etc.)			k, White,	etc.
9	at', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give 10 Year or Dates:	944-19	46	1∐ Yes 2	XNo	Specify:				Specify	Wh:	ite
2-0036	in 72 hours a n "natural", c	Completed	15. Decedent's En (Specify only highest gra			(Give	dent's Usual kind of work	k done d	during most	t of worki	ng	16b. K	ind of Bu	ısiness/în	dustry
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and	d be funtal h) Be	Edward Smrcka							Beat	rice Bu	ırke			
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			Decedent's Name (First, Middle, Last)						2. Date of D	eath		3. Time of Death
п	Physici /Media		Gertrud Tucker						June 2	.5. Da	y Year 2004	7:20 P M
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			Usual Residence of Decedent	97		Nov. 5, 1906 Marylar						yland
	ylan how		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
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36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinant for reciling at once.	by Funeral	11, Marital Status 1 □ Never Married 2 □ Married 3 ♥️ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:		If Yes, s	cedent of His pecify Cubar 2 🔯 No	n, Mexican, Pu	(Specify Yes or Netro Rican, etc.)	0-	14. Race - Am Black, Whi Specify: Wh	te, etc.
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Jar	12 sh and Is m		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Ma	ailing Addre	ss (Street a	nd Number or	Rural Route Numb	er, City	or Town, State,	Zip Code)
	1 and Health hm 27 ther t		Judy Miller / Daug	nter	20b. Place of Dis	Vill	a Dri	ve Hel	bourne,	FL,	32940 ocation - City or	Taum Chat
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	. = 1. 0		1		\circ		241	690		01	3/28/	'nv
			30. Name and a dress of person who con	npleted cause of d	eath (Item 23a) (Typ	e, Print)	- 11	- 10			1 20	37
_			STOVE Hamilia	-	110 Day	TWIS .	5 Hw	y #4	00 A	NNA	PULS,	vo 2140/
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DHMH 17 Rev 1/2001

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/Medical		TEDDER		4b. City, Town, or L	07			9:35pm
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Funeral . Director	214-34-3344 ¹⁵ X ^M		Months Days	Hours Min.	JUNE 2	y, Year) 3 • 1937	Country WEST	ce (State or Foreign y) VIRGINI
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ē 22 5	A	/as Decedent Ever in U,S. rmed Forces? Û Yes 2□NN MY Ves, Give ARMY ear or Dates 5 4 - 6 2	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ XNo		Becity Yes of No- Rican, etc.)	Specify	e - Americar ck, White, et	
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arylan should b and Ments marked umerice	BENJAMIN FRAN	NKLIN TEDDER		ELIZA	BETH J	ETT		
	19a. Informant's Name/Relationship (Type, P.	Print) 19b. (Mailing Address (Stree	t and Number or Rui	ral Route Numbe	r, City or Town,	State, Zip C	(ode)
, E & C &	ROSE M. TEDDER-SPO		7 HUCKLE	BERRY D				
O % > E E	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remov	an nom State	Disposition (Name of crematory or other pla	l l	Date	20c. Location -		
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Baltimo pemit. Pag Depertment important: I	21. Signature of Funeral Service Licensee	M00479	22. Name and Addre	FUNERAL	L SERV	CE.P.	Α.	
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ng Ph ng Ph fter th ineral	27. Manner of Deeth 12 Neturel 5 Pending	e. Date of Injury (Month, Dey Year) 28b. Tir	ury Wo		28d. Describe h	ow injury occurr	ed	
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iVision Att	4 Homicide determined 28	 e. Place of Injury - At home, farn building, etc. (Specify) 	n, street, factory, office		28f. Location (S City or Tow		er or Rural F	Rou <i>te Number</i> ,
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he Hospif in 24 hour he Funer pletely fall	(Check only 2 Medical Examiner: C	: To the best of my knowledge, on the basis of examinetion and/	death occurred at the ti or investigation, in my	me, date end place, opinion, death occur	and due to the d red at the time, d	ause(s) and ma late and place, a	nner as state and due to th	ed. ne cause(s)
Division o To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:	29b. Signature and title of certifier	nd manner stated.	29c. Licens	se number		29d. Date signed	d (Month. Da	y, Year)
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at.	20 Name and historic of across into across	and cause of death (Item 00c) (T			1	000/0	<i>,</i>	2004
91	30. Name endaddress of person who completed Ashvin J. Patel,	MD 102 Paul	Mellon Co	urt Sui	te 102	Waldon	cf, M	D 20602
State	31. Dete filed (Month, Day, Year)	32. Registrar's Signature	1 11 5					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Roger L. Tuel 04 - 4184State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AKG Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** ROGER LESLIE TUEL, SR. 6:26 A June. 26, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7000 Main Street Queenstown Queen Anne's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1**X** M 2□ F 63 215-38-2000 Director FEB. 7,1941 WEST VIRGINIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 Is marked other then "neturel", or items 23a or 28e-1 show other treumetic event, the Medical Exercit at most be notified at 1 XYes 2 □ No Director MD QUEEN ANNE'S QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 7000 MAIN STREET 21658 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other then "neturel", or Itel 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed Woivorced If Yes, Give Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER BUILDING CONSTRUCTION 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEWIS ERVIN TUEL ٥ MARY HESTER SIMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # Health ar 7000 MAIN STREET QUEENSTOWN, MD LEWIS KEMP TUEL BROTHER 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of I 6/28/2004 1 ☐ Burial 2XXX remation 3 ☐ Removal from State õ permit. Page Department (Importent: If any injury or once. STEVENSVILLE, MD CHESAPEAKE CREMATION CENTER, LLC A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death mmediate Cause (Final Priysician Atheroscleratic cardievascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ is certificate has been signi director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 XYes 1 XYes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCH C Hospital: 2 XXYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending within 24 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. respers MD June 26, 2004 leted cause of death (Item 23a) (Type, Print) Tasha 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

JUN 2 9 2004 Gene & Sport

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year A M 2004 7:42 June Ε. White Margaret 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Henderson Caroline 25841 Shults Road If Under 1 Year I If Under 24 Hrs. 8 Date of Birth Months Days Hours Min. (Month, Dey. Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 1 ☐ M 2 🗓 F Dec 7, 86 Virginia 579-18-5241 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Caroline Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25841 Shults Road 21640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Charles Sherman Delsia Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denton, Maryland 21629 530 N. 6th Street daughter Bonnie Dove 20b. Place of Disposition (Name of cometery, crematory or other place) Chesapeake Cremation 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/10/2004 Chester, Maryland Center 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home PA Conscious Maryland 2163 21. Signature of Funeral Service Licensee PO Box 160 Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ere bra disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undergray Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No

Physician /Medical Examiner

Department of H Important: if its any injury or of

permit. Page Department

Physician

/Medical

10a State

Director

Completed by Funeral

Be ٥

Examiner

Funeral

Director

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or items 23a or 28a-f show ury or other traumatic event, the Modeal Examiner trust be nother traumatic.

Baltimore, Maryland 21215-0036

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IF FEMALE

the death certificate be executed To the Hospital or Attanding Physician: within 24 hours after death. within 24 hours after deau...
To the Funeral Director: Af

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Records,

Vital

Division of

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Completed	_
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To	_
tlon:	27

Was case referred to medical examiner?

5 Pending investigation

6 Could not be

determined

1 Yes 2 No

Manner of Deat

Natural

2 Accident

3 Suicide

29a. Certifier

4 Momicide

	Sta	ate	
leg	ist	rar	
eg	ist	rar	

Medical

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month) Day, Year) 29b. Signature and Jala of certifier

3 DOA

28c. Injury at Work?

address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year) 2004

32. Registrar's Signature

1 Inpatient 2 ER/Outpatient

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Maryla		artment of H			giene Reg. No.	2001	22138	
H	Observation!	4	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	/ Yeer	3. Time of Death	
	Physici /Medio		Catherine	Mary	Willir	ıg				2004	4:59 A ^M .	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	th	4c.	County of Deat	th	
			Chesapeake Hospice			Linthic				ne Arun		
в	Funeral		5. Social Security Number 6. Se 220–18–8331	x 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Da	th ly, Year)	9. Birt	hplace (State or Foreign	
	Director		Usual Residence of Decedent	Λ /0				March	1, 1	926 Ma	ryland	
	yland now		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits	
	Mar.	tor	Maryland Anne Aru	ndel Ar	nnapoli	S					1 ☐ Yes 2 ☐ No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	ountry?	
	th wi	ai	1020 Sextant Cour	t		21401			Unit	ed Stat	es	
	r dea	Funerai	11, Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.))-	 Race - Ame Black, Whit 		
36	s afte	by Fi	1 Never Married 2 Married 3:□ Million Married 2 Married	1 ☐ Yes 27 No If Yes, Give Year or Dates:		1 □ Yes 2★□ No	Specify:			Specify: Wh	ite	
21215-0036	72 hours after death with the Maryland neturel', or Itama 23e or 28e-f ehow dreal Exeminer must be notified at	ed b	15. Decedent's Edu		16a Deced	dent's Usual Occup	nation		16h Ki	nd of Business/	Industry	
7.	in 72 n ne	piet	(Specify only highest grad	de completed)	(Give	kind of work done DO NOT use retire	during most of wa	orking	100.14	nd or basinosa		
212	d within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Hom	emaker			Ow	n Home		
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Baltimore,	Pages 1 nent of H int: If itel		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ I	neiliuvai iiulii State		sition (Name of natory or other pla		Date	20c. Lo	cation - City or	Town, State	
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B.	e death he atte ed for	sick	in the past 12 months?	4☐Pregnant at time of 9☐Unknown		Other (specify)				Month	Day Year	
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orc	law requires as been sign 2 should be	ted								3 □ Pr	obably 4 Donklown	
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E F	Th ate pag							1 ☐ Yes	rmed? 2.2 No	1 Yes	2 No	
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	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying Phy	/sician: To the best of my kr	nowledge, death	occurred at the ti	me, date and plac	e, and due to the	cause(s)	and manner as	stated.	
	n 24 I ne Fu he Fu	edical	(Check only 2 Wedical Exam	iner: On the basis of examir and manner stated.	nation and/or in	vestigation, in my o	opinion, death occ	urred at the time,	date and	place, and due	to the cause(s)	
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			30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type,	Print) Ra	staate 6	2d. Al.	1Wa	polis 1	004 ud. 2140	
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	/Medic Examin		4a. Fecility Name (If not institution, give 2114 'Trevanion Ro			, ,	Town, or	Location of	Death			County	of Death	untsz	-
-	Funeral		5. Social Security Number 6. Se	x 7. Age (In yr	s. last birthday) 5 Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)		9. Birthp	place (State o	
	Director		Usual Residence of Decedent	,		anting				Mar. 4	, 19	29		sylvan	
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	with the 3a or 28	1 Dire	10e. Street and Number 2114 Trevanion Road 21787								10g. Citi Unit		/hat Cour	-	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show mithoriant: if item 27 is marked other than "natural", or items 23a or 28a-f show hippy or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced		Was Deced f Yes, spec		spanic Origi n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or National Rican, etc.)	0-	Black	- Americk, White,			
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	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship (T) Tammy Panek / dau			-		^{nd Number} n Roa		Route Numb Taneyt					
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)	To the within To the compl	Me	29b. Signature and title of certifier	lward, M7		29c.	License	number 851(-	(Month, L	Day, Year)	
	10		30. Name and address of person who co	0/-	ROLL S		JEST	MIN	उ त्तर	z Mi		115			
	Sta Registr			3 2004)	nature	Pro	and the	¥ c		,					

			State of Maryland / Dep. 1 - For State and From 17/16/2	artment of Health and Me		ene g. Ng2	22110				
	9		Decedent's Name (First, Middle, Last)		. Date of Death Month	100	3. Time of Death				
	Physicia /Medic		Valentine Jose		une 2	25 2004	2:08pm M				
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat					
	Funeral		4002 Lomar Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Mt. Airy If Under 1 Year If Under 24 Hrs. 8	. Date of Birth		hplace (State or Foreign				
	Funeral Director		304-03-0861 10x 2□ F 87 Yrs.	Months Days Hours Min.	(Month, Day, an. 12	1917 Inc	diana				
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	the N	Directo	Maryland Frederick Mt. Airy 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?				
	h with	o le	4002 Lomar Drive	21771		United Sta	ates				
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20	n 72 hours after death with the Maryland "natural", or items 23a or 28e-f ehow solical Examination ust be notified at	by Ft	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No	1 ☐ Yes 2 🖾 No Specify:		Specify:	• .				
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altimore,	of Health item 27		20a. Method of Disposition 20b. Place of Dispo	osition (Name of omatory or other place) 6/28/2		Oc. Location - City or					
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Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumetic evonce.		mal OUNWO 2	2 Name and Address of Facility 11n L. Molesworth P 6401 Ridge Road, Dan	mascus.	Maryland					
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or r	espiratory arre	st,	Approximate Interval Between Onset and Death				
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Division	or Attending Physicien: after death. Director: After this certifical in by the funeral director.	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,				
ā	tel or rs afte al Dir ed in	Certification:	Building, etc. (Specify)		0.00 07 101111	J. W. C.					
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by t	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or in and manner stated.								
	Vithii To th	Me	29b. Signature and the observation MT	29c. License number	29	d. Date signed (Mont	h, Day, Year)				
)			1990/////////	D0046096	J	une 28, 20	004				
	5		30. Name and address of person who completed cause of death (Item 23a) (Type		ows 1 or 4	21771					
	Sta	te.	Hope McIntyre M. D. 1502 South Main 31. Date filed (Month, Day, Year) 32. Registrat's Signature		aryiand	Z1//I					
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			For State	State of Marylan	d / Depa		Health and		iene	l. 20111	
		_	1 - State Registrar 1. Decedent's Name (First, Middle, La	net)	Cei	runcate or	Deam	2. Date of Deat	g. Nd. UU	3. Time of Death	
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	/Medic		4a. Facility Name (If not institution, gir			4h City Town	or Location of Dea		26, 200, 4c. County of		
	Examin	er	Buckingham's Cho					aut			
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. I	ast birthday)	Adams If Under 1 Year	If Under 24 H		Fred	erick Birthplace (State or Foreign Country)	
	Funeral Director		214-18-1713	1□M 2\sqrt{87}	Yrs.	Months Days	Hours Mi	n. (Month, Day, Dec. 25,		Country) Cennessee	
-	<u> </u>		Usual Residence of Decedent					Tuec. =5			
	inylar show	_	10a. State 10b. County		, Town or Lo	ocation				10d. Inside City Limits	
	89-fs	cto	Maryland Freder	Ad	amstown				1 ☐ Yes 2 /_\ No		
	vith th	Directo	10e. Street and Number			10f. Zip Code	1.0	10	g. Citizen of Wha	at Country?	
	s 23s		3200 Baker Circ	le, Apt. I-106	2 142	217		10 7 7	United		
	er de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.	
3	ours after death with the Marylan rel; or Items 23a or 28e-f show Erer; it er notest be inclifted at	by F	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White	
2-003e	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23a or 28e-f show Medical Evaritzer mast be notified at	D E	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		6b. Kind of Busin	ess/Industry	
2	d within 72 ho piene. r then "natur	ble	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	eduring most of weed)	rorking			
1212	gien di	Completed	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I I	C16	erk			US Gover	nment	
9	be filed tal Hygid d other event, I	Be (17. Father's Name (First, Middle, Las	7)			18. Mother's N	ame (First, Middle, M	laiden Sumame)		
<u>a</u>		2	Gray Haggard Ba	con			Cather	ine F. Bur	ns		
Maryland	2 sho and sma		19a. Informant's Name/Relationship		19b. Mailir	ng Address (Stree	t and Number or I	Rural Route Number,	City or Town, Sta	te, Zip Code)	
<u>√</u> `	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	1 2	Catherine Engel		8214	Fox Hunt	Lane, 1	Frederick,	MD 2170		
0	m 0 1-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [☐Removal from State	emetery, crei	osition (Name of matory or other pla	ice)		Oc. Location - Cit		
Baltimore,	permit. Page Department of Importent: If eny injury or once.		* 4 □ Donation 5 □ Other (Spec	_{fy)} Fre	derick	c Cremato	ry Jun	e 28,2004	Frederic	k , Maryland	
a C	Sermil Depar Mpor Mpor No ir		21. Sign vore of Funeral Service Lice	Insee				auffer Fu			
	40 = 4 4		232 Part Splay the disease to an	Jakhe				Pike, Fre			
			231. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	. Do not en	ler title mode or dy	ing, such as cardi	ac or respiratory arre	51,	Approximate Interval Between Onset and Death	
	mysician /Medical	(i)	In mediat wase (Final disease or condition resulting in death)	a. A. > (<u> </u>	1)				(1A32) 05	
	Examiner			Due to (or as a consequ	uence of):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	sence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							g .	
a a	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	uence of):			-			
_	95 9	cal		d							
89		Med	IF FEMALE:								
ROX	ith ce tendii or use	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		∃Ectopic pregnanc	су		23d. Date of Month		
	it the death certific by the attending p tached for use as	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify)			MOILI	Day Year	
<u>.</u>	that th	Phy	Part II. Other significant conditions	contributing to death but not recu	ulting in the u	ndoshina asuso a	von in Port !	23a Did tob	acon use contribu	te to the cause of death?	
Ś	& F 8	by	-	18EM	aking in the d	ilderlying cause g	voilin raiti.			Probably 4 Unknown	
Vital Records,	w require been sig should b	ompleted			ía.		Α	·			
ě	sicien: The law certificate has b irector, page 2 s	ldm	(Hnovic	rympHoch 11	CH	MEMIA	<u>+</u>	24a. Was an autopsy perform	prior	e autopsy findings available to completion of cause of h?	
		O						1 ☐ Yes 2	2NO 10	Yes 2 110	
=	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:	5D/0			eath (Check only one			
	Phy rald	⊢	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Time of		at A Triursing	Home 5 Resider		Specify)	
0	ding l th. : After s funer	tlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day Year)	Injury		ork?]Yes 2∐No				
DIVISION	tal or Attending s after death. sł Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not a determined	1 286. Place of injury - At no	me, farm, str	reet, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,	
5	spital or ours afte nerel Dir filled in	Cert	4 - Hombide	building, etc. (Specify	')			Chy or rown,	State)		
	e Hospital or 24 hours afte e Funerel Dir letely filled in I		29a. Certifier 1 Certifying P	hysicien: To the best of my knowniner: On the basis of examinat	wledge, death	h occurred at the t	ime, date and place	ce, and due to the car	use(s) and manne	r as stated.	
	To the Hosp within 24 ho To the Fund completely f	Medical	one)	and mapher stated.							
	To To	2	29b. Signature and title of certifier	()			se number		d. Date signed (N	ionin, Day, Year)	
			1	the mo			-3191	L	6/28	107	
	10		30. Name and address of person who			- 1	6 Cmi	CAPILL	10 00	707	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signal		4	4, snet	je ivitvi,	ND 91		
	Sta Registr		JUN 28		1	9 April	uku				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 26**Physician** June 2004 WILLIAM HARRY WHIPP, SR. 8:10 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vindabona Nursing Home Frederick Braddock Heights If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Aug. 4, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1₽M 2□F 215-20-8563 78 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4301 Dover Drive 21703 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: WWII Specify \$ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Whipp-Barger Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Carpenter & Builder Home Builders 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Roth Whipp Naomi Druscilla Wertz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Grubbs (Daughter) 4301 Dover Drive, Frederick, Maryland 21703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Manor Ref. Church Cem. 6/29/04 Frederick, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service Licensee ROBERT C. DAILEY & SON, FUNERAL HOMES, P.A. once. 1201 NORTH MARKET ST., FREDERICK, MD 21701 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung Cance Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed burial-transit and Due to (or as a consequence of): the attending physician thed for use as the buria Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performe certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: Surring Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28h. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No To the Hospitel or Attence within 24 hours after death To the Funerel Director... the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUNSWICK, Mo 2176 1+1 Ho, CHAN-HUNG MID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 9 2004 Registrar

		1 - For State Ragistrar	State of	Maryland	-	artment of F rtificate of		ind Me		iene :::No2014	22163
Physic /Med		1. Decedent's Name (First, Middle, L LETA LOUISE 2				-			Date of Death		3. Time of Death 10:50 AM
Exami		4a. Facility Name (If not institution, g 13 MONROE STREE		nber)		4b. City, Town, o				4c. County of Dea CARROI	
Funeral Director	ì	213-09-5447	Sex 1 ☐ M XXF	7. Age (In yrs. las 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. OX	Date of Birth (Month, Day, TOBER	^{Year)} ,1912 1	thplace (State or Foreign MARYLAND
the Maryland 28e-f show	or	Usual Residence of Decedent 10a. State 10b. County MARYLAND CAR	ROLL	10c. City,	Town or Lo	cation ESTMINST	ER				10d, Inside City Limits 12 Yes 2 □ No
th with the A 23e or 28e-(ust be notifi	Funeral Director	10e. Street and Number 13 MONROE STREE				101. Zip Code 2115				og. Citizen of What Co	ountry?
after dea or Itema	þ	11. Marital Status 1 Never Married 2 XX Arried 3 Widowed 4 Divorced	12. Was Dece Armed For	XXNo B	'	Was Decedent of H f Yes, specify Cuba	ispanic Orig	in? (Specif Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: WI	
in yearing Z. L. L. J. Coopers at should be filed within 72 hours at a Mental Hygiene. marked other than "natural", or matic event, the Madical Exprin	Completed	15. Decedent's (Specify only highest g			(Give	dent's Usual Occup kind of work done OO NOT use retired SEAMSTR	during most i)	of working		6b. Kind of Business	/Industry
nd 2 should be filed the and Mental Hygis 27 is marked other treumatic event.	To Be C	17. Father's Name (First, Middle, Later PIERCE HARRISON		N ZILE			18. Mother		First, Middle, M	faiden Sumame)	
1 and 2 shou Health and N tem 27 Is man		19a. Informant's Name/Relationship		ND	19b. Mailin	g Address (Street ONROE ST	REET,	or Rural R WES	loute Number, IMINSTE	City or Town, State, IR, MD 211	Zip Code) 5 7
Page nent o		20a. Method of Disposition XX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cen	netery, cren	sition (Name of natory or other place N MEM GAR	DENS	Date 6/26/		Oc. Location - City or	
permit. Departr Imports any inji		21. Signature of Funeral Service Lic	ss of Facility ORAW STRE		AL HOME WESTMIN	P.A. ISTER, MD	21157				
Physician /Medical		23a, Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. A	aused the death. ach line. Oercalc or as a conseque	emic		g, such as c	cardiac or re	espiratory arre	st,	Approximate Interval Between Onset and Death
reate be executed mysician and site burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ince of):	tion fe	e M	align	nancy		10.22.03
the death certifing the attending ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 🗀 Live bi	come of pregnance th 2 Fetal di ant at time of dea	léath 3 🗀	Ectopic pregnancy Other (specify)			Ŧ	23d. Date of del	ivery Day Year
quires that:	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did toba	the cause of death?	
	Completed by	,							24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of
ding Pl	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 to No 27. Manner of D-ath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date o (Monti	ipatient 2 EF f Injury 2 n, Day Year)	P/Outpatient 8b. Time of Injury	28c. Injun Worl	er: 4 ☐ Nurs	sing Home 28d		ce 6 Other (Spec	cify)
5 \$ € € €	Certification:	3 Suicide 4 Homicide Suicide 4 Homicide Suicide Suicide Gould not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)								eet and Number or Ru State)	ıral Route Number,
To the Hospital or within 24 hours after To the Funeral Direction completely filled in the filled in	Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	Mysician: To the aminer: On the ba and mann	sis of examination	edge, death n and/or inv	occurred at the timestigation, in my of	ne, date and pinion, death	place, and occurred a	due to the cau at the time, dat	use(s) and manner as e and place, and due	stated, to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	2				1172 4172	5	290	d. Date signed (Montl)	
4		30. Name and address of pers with SHARON ALONGI	1 1	of death (Item 2 8 WASHIN		Print) HGHTS MEI	DICAL	CTR,	WESTM	INSTER, MD	21157
St Regist	ate rar	31. Date filed (Month, Day, Year)		gistrar's Signatur	G	Ann de	,				

			State of Maryland / Department of Heal		-	_	
			- State Registrar Certificate of Dea	ath	Reg.	No. 2 0 0 L	22144
	Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death Month,	Day Year	3. Time of Death
	/Medica	al -	JOSEPHINE CLARA AMBROSE		July	4 2604	1735 M
	Examine	er	4a. Facility Name (<i>If not institution, give street and number</i>) 4b. City, Town, or Loca Washington County Hospital Hagersto			4c. County of Deatl	
	Funeral		Social Socials Alumbar S. Sov. 7 Age (In use lest highday) If Under I Year If U		Date of Birth (Month, Day, Ye	Washir 9. Bjrd	nplace (State or Foreign untry)
	Director		219-14-8485	lours Min. Ma	(Month, Day, Ye arch 13,	1925 Ma	aryland
	pu >	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	show						1√2 Yes 2 □ No
	the N	ect	Maryland Washington Hagerstown 106. Street and Number 106. Zip Code		10a.	Citizen of What Co	
	3a of		432 Michigan Avenue 21740			U.S.A.	,
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispani If Yes, specify Cuban, Me	nic Origin? (Specify	y Yes or No-	14. Race - Amer Black, White	
36	be filed within 72 hours atter death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Eraninar must be notified at	y Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes Give 1 □ Yes 2 □ No So		un, 6to.)	Specify: Wh:	
Ö	hours tural	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	`	166	o. Kind of Business/l	
7.	in 72 n "na	Completed	(Specify only highest grade completed) (Give kind of work done during	ng most of working	100	7. Killa of basinessi	industry
212	d with giene grant	E	College (1-4or 5+) Cashier		G:	rocery S	Store
Pu	al Hys	Be C		Mother's Name (F	irst, Middle, Mai	den Sumame)	
yla	Ment Marke Marke	2	Charles Gordon	Mamie			lohrer
Mar	12 sh h and 7 is m traum	И	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N				
e,	1 and Healt em 2	1112	Raymond G. Ambrose Husband 432 Michigan 20a. Method of Disposition (Name of	Avenue		CSTOWN . Location - City or	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination that the notified at once.		1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Seurial 2 □ Cremation 3 □ Removal from State 1 □ Seurial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Broadfording Cemeter	rv 07-08-	-04 H	aneretown	Maryland
alti	mit. F partm portar / injui			Facility	7 11	-	, Maryiana
ä	permi Depa Impo any ir		21. Signature of Funeral Service Licensee R. hall Brady 22. Name and Address of Fundrew K. Co. 40 East Anti	orrman Fu ietam Str	neral H eet. Ha	ome, Inc. gerstown,	Md. 21740
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	uch as cardiac or re	espiratory arrest,	Mont Billian - S	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death 2 YEARS
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	-1140			
		ē	Sequentially list conditions, if any, leading to immediate Due to (c) as a consequence of).				
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
0,	ate be executed hysician and he burial-transit	Ĭ.	resulting in death) Last Due to (or as a consequence of):				
8760,	hysic the bu	lica	d				
x 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			Old Date of deli	
Вох	atten for u	cian	in the past 12 months?			23d. Date of deli Month	Day Year
0	that the de led by the a detached f	nysi	1 Yes 2 4 9 Unknown 9 Unknown				
Olvision of Vital Records, P.O.	res that the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I	Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	v require been sig should b	ted	LARONIC AND LACONIS MISSPITZAVORY I	TALLUKI	1 4 Fes	2 □ No 3 □ Pro	obably 4 Unknown
ecc	law r	Completed	CONGRIVE NEART PAILURI	1=	24a. Was an autopsy	prior to o	topsy findings available completion of cause of
H H			& CHITERAC BROKENOPNEUMOLYIA		performed 1 ☐ Yes 2 ☐		2□ No
Vit	Physician: The law this certificate has tral director, page 2 s	Be	examiner?	. Place of Death (C			
of	Physer this eral d	2:10	27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at		I. Describe how i	e 6 □Other (Specinjury occurred	iry)
ion	Attending or death. ector: After by the fune	atio		2 🗆 No			
$\leq \frac{1}{2}$	er der recto	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Stree City or Town, S	t and Number or Ru State)	ral Route Number,
4 5	Hospital or 4 hours afte Funeral Dir tely filled in						
	e Hospital or Al	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	date and place, and on, death occurred a	I due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Mec	one) and manner stated. 29b. Signature and title of certifier 29c. License num	ımber	29d.	Date signed (Month	n, Day, Year)
	F ≤ F ŏ		Calut Band O PERSUNAL PHYSICIANS D	0004	259	J111	5 200 CL
	h		30. Name and address of person who co ed cause of death (Item 23a) (Type, Print)	1000		002	, , , , , , , , , , , , , , , , , , , ,
	Ü		REBERT BRULL 1459 GOTOMAC STREET A	HAGERI	TOWN,	MB 2	1242
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	(,		
DHI	MH 17 Rev 1/200		JUL 1 4 2004 Janua & Jacke				
Dill		J 1	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND ITEM #20b PER FH G833 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:00 A M OUIS JULY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN HOSPITAL CENTER BALTIMORE. NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 2, 1940 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 □ F 218-36-7002 64 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 77 is marked other then "natural", or Items 23e or 28a-f show traumatic event, the Medical Erect met most be redified at 1 ¥Yes 2 □ No Directo N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 HIGHGATE DRIVE 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be APPEL DANIEL JEANETTE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 BERRY VINE DRIVE - OWINGS MILLS, MD 21117 f Health item 27 i ETHEL SEIDMAN / COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) VEREIN 7/13/04 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any injury or once. PROGRESSIVE RUDOMER 7/14/2004 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Tolelo 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE Pnysician RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIABETES MELLITUS. Sequentially list conditions, it any, leading to immodate cause. Enter Underlying Cause, (Disease or injury that initiated events Due to (or as a consequence of) law requires that the death cartificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown CARDIUMYOPATHY. 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes ral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 patient 1 Tyes Certification: To 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainle, as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HYSICIAN 42723 JULY 2004. 30. Name and address of roon who completed cause of death (Item 23a) (Type, Print) NORTHWEST AVVERAHALLI HARISH SLOLD CO HOSPITAL AVVERAHALLI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1

4 2004

32. Registrar's Signature

5401

ROAD

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Marylan		epartment or r Certificate of		-	gierie Reg. No.? 1	01.	22116
	Physici	an	1. Decedent's Name (First, Middle, Last)	,				2. Dete of De		Year	3. Time of Death
Aug.	/Medic		Ezell Barrett					July .	10, 2004	. 1	L:55 A.M.
	Examir		4e Fecility Neme (If not institution, give				4b. City, Town, or		,		
			Southern Maryland			MILL IN A VO	Clinton			e Geor	_
	Funeral Director		5. Social Security Number 244-66-7988 Usuel Residence of Decedent	7. Age (In yrs. 3 M 2□ F 60	last birtho	Months Davs	If Under 24 Hrs Hours Min.		y, Year) 1944	9. Birthplac Country	e (State or Foreign)
]	E 8 =		10a. State 10b. County	10c. Cit	ty, Town o	or Location				10d.	Inside City Limits
	E P	ğ	MD Prince Ge	eorge's Te	emp1e	Hills					1 ⊠ Yes 2 □ No
4	128	9	10e. Street end Number			10f. Zip Code			10g. Citizen of W	Vhat Country	?
		O E	4411 Harvest Road			20748	}			US.	A
ဥ္	permit. Fages I ento 2 should be lied within 7 z hours enter death with the marylend permit ento of Health and Mental Hygiene. Important: If lear 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at once.	y Funeral Director	1 ☐ Never Married 2 ☑ Married	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	I,S.	13. Was Decedent of I If Yes, specify Cub		specify Yes or Noto Rican, etc.)	14. Race Blac	e - American k, White, etc.	
2	e de la constanta	d D	3 ☐ Widowed 4 ☐ Divorced	Year or Detes:							
Baltimore, Maryland 21215-0020	within 72 meters of the Medica	Completed by	15. Decedent's Educ (Specify only highest grede Elementary/Secondary (0-12) 1 2		16e. D (C	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire Truck Driv		rking	16b. Kind of Bu		try
ס :	H P H	ပို	17. Father's Name (First, Middle, Last)		1	TIGER DIIV		me (First, Middle,			
<u>a</u>	ental ced o	To Be	Unavailable				Mary	Barrett			
2	In Mark	F	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. N	failing Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Co	ide)
Š	olth ell 27 is r trat		Betty M. Barrett -	Wife	441	1 Harvest	Rd. Tem	ple Hill	s. MD 20	748	
more,	rages in lent of Her nt: If Item ry or othe	1	20a. Method of Disposition 133 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Res	Place of D	isposition (Name of crematory or other place ction Ceme	cel	Date	20c. Location - Clinto	City or Town,	, State
Balti	Depertm Depertm Importa any inju		21. Signature of Funeral Service License	1 material		22. Name and Address	444	atney's ue, NW,			
**************************************	hysician		23a. Pert1. Enter the diseese, or complishock, or heart tailure. List only on	cations that caused the deat	th. Do not	enter the mode of dyi	ng, such as cardia	or respiratory ar	rest,	Int	pproximate erval Between aset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	End Stage	lung or as a ooi	Cilnum nsequence of):				40	kingu-
	o #	edical Examiner	- 1							i	
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P.O. Box	the	Physician/N	Part II. Other significant conditions con	tributing to death but not res	ulting in th	ne underlying cause gi	ven in Part I.				e cause of death?
7	dete	F.						10'	res 2∐ No	3 ☐ Probab	ly 4 🗹 Unknown
Division of Vital Records,	ins raw requires that the deem continued to executed attends been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit	Completed by							an autopsy med?	availal	autopsy findings ble prior to etion of cause th?
¥ į	sector. The law certificate has t lirector, page 2 s	E						1 1 Y	98 2 KNO	1 □ Ye	es 2 No
<u>e</u>	tifice tor, p	Bec	25. Was case referred to medical	-			26. Place of De	ath (Check only o	ne)		
> 3	s car direc	ToE	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	ER/Outpa	atient 3 DOA Oth	ner: 4 Nursing H	lome 5 ☐ Resid	lence 6 Dothe	r (Specify)	
ouo	Attention of the state of the fundation	ation: 1	27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Tim Inju	e of 28c. Inju ry Wo	ry at		ow injury occurre		
	s efter de al Directo ed in by th	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At he building, etc. (Specif	ome, tarm fy)	, street, factory, office		28t. Location (5 City or Tow	Street and Numbe m, State)	er or Rural Ro	oute Number,
	to the hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certification:	29a. Certifier 1 Certifying Phys cone) 1 Certifying Phys 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, d	r investigation, in my o	opinion, death occu	rred at the time,	date and place, a	nd due to the	e cause(s)
	To the com	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed		, Year)
	1.		Roston Familia	- 71.0		D	43446		7.1	11.04	
	M		30. Name and eddress of person who con	HIF AR MO	n 23e) (Ty 980)	ne Print)		st Silva	spring 1	mo 20	902
	Sta Registr		31. Date filed (Month, Day, Year) 1 4 2004	32. Registrar's Signa	ature &	Georgies)	1		. 0		

DHMH 16 Rev 6/95

			1 - For State Registrar AMEND ITEM	State of Ma #10c&17 Pl	ryland ER AN	d/Bepa NA Cer	utmen tificati	5914 e of L	904h a Death	and Mer	tal Hygie		n L	22117
H			1. Decedent's Name (First, Middle, La	st)							Date of Death Month	Day	Vane	3. Time of Death
	Physici /Medio	_	Margaret L. B	utt							Month JUL	Pay 8,	2 19 12 14	4 9:30A M
	Examin		4a. Facility Name (If not institution, give Saint Joseph		Cent	ter	4b. City,	Town, or	Location o	of Death OWSON		4c. County	of Death	timore
	Funeral Director		5. Social Security Number 6. S 205–20–0716	ex 7. Age	(In yrs. la	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8. Min. Ma	Date of Birth Month, Day, Ye y 3, 19	19	Cou	nplace (State or Foreign untry) Vland
	ט		Usual Residence of Decedent											
	arylar ahow dest	_	MD Baltimo	w.o.		, Town or Lo		נויויו ז	ERVII	TP				10d. Inside City Limits
	Ba-f	Director	302020	Le	,133	Inthie			TVATT	باباء				1 ☐ Yes 2X No
	with th		10e. Street and Number	D 1			10f. Zip		000		10g.	Citizen of \	What Cou	untry?
	s 23	erai	1105 Longbrook	12. Was Decedent E	ver in II s	S 13 V	Vas Decer		093	gin? (Specify	Vas or No-	US 14 Bac		ican Indian,
20	be filed within 72 hours after death with the Maryland its Hygiene. A control than "natural", or Items 23a or 28a-f ahow adont, the Medical Exacilmet must be mullified at a vent, the Medical Exacilmet must be mullified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:			Yes, spec	cify Cuba	Specify:	, Puerto Rica	n, etc.)	Blad	ck, White	, etc.
0500-C	2 hou		15. Decedent's Ed	lucation	1	16a. Deced	ient's Usua	al Occupa	ation		168	. Kind of B	usiness/l	ndustry
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yland	2 should be and Mental is marked raumatic av	인	Henry A. Lowe	ry S r HENR	Y A.	LOWRY	,SR.		Ali	lce Har	dester			
Mar	2 short and is m		19a. Informant's Name/Relationship (19b. Mailin	g Address	(Street a	and Numbe	er or Rural Ro	ute Number, C	ty or Town,	State, Zi	ip Code)
a) S	T1 1- 1		Erna Kesler/daugl	nter	20h Bi				k Roa	d Luth	erville			
9	ges 1 t of H If ite or otl		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	200. PI	ace of Dispo metery, cren	natory or o	ne or ther place	θ)	Date	200	. Location -	City or I	Town, State
Saitimor	Pa tmen tant: jury		* 4 Donation 5 ☐ Other (Specif		/									
g D	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Eunoral Sprice Licer ROTATO	/// Ml	0	Ба	ate /	Anato	s of Facilit Duy B MD	277d16	55 W. B	altim	ore	Street
			23a. Purt1. Enter the disease, o com	plications that caused one cause on each lin	the death e.	. Do not ente	er the mod	e of dying	g, such as	cardiac or re	spiratory arrest,			Approximate Interval Between
1	Physiclan		Immedia Cause (Final disease or ondition	, SEPSI	3									Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):								
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):								
_	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequ	ence of):								
0/0	iicate be executed physician and s the burial-transit	ajE				,								
	ficate physics the	edicai		. d										
XOD	w requires that the death certif been signed by the attending should be detached for use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy						23d. Dat	te of deliv	/ery
ň	death e atte d for	Physician/M	in the past 12 months? 1 □Yes 2 ☑No	1□Live birth 4□Pregnant at			Ectopic pr Other (sp					Мо	nth	Day Year
	t the by the ache	hys	9 Unknowh	9□ Unknown										
ν, -	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to death bu	it not resu	Iting in the ur	nderlying c	ause give	n in Part I.		23e. Did tobac	co use cont	ribute to t	the cause of death?
SDJ	en sig		_URINARY TRACT IN	FECTION							1 ☐ Yes	2 No	3 Pro	bably 4 Unknown
ecor	a 2 C	Completed	PARKINSON'S DISE	ASE							24a. Was an autopsy	24b. \	Were auto	opsy findings available ompletion of cause of
r	The ate h page	mo.	RHEUMATOID ARTHE								performed 1 ☐ Yes 2 🔀	? (death?	2 2 No
\ [a \	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?								eck only one)			
> 10	Physician: this certific ral director,	일	1 ☐ Yes 2 📉 No	Hospital: 1 Inpatier		ER/Outpatien					5 Residence			ity)
	ding P	on:	27. Manner of Death 1	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		8c. Injury Work	(?		Describe how i	njury occurr	red .	
<u>20</u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М	_	res 2 🗆 i					10
UIVISION	al or Attending F s after death. Il Director: After id in by the funera	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At hoi . <i>(Specify</i>)	me, farm, stre	et, factory	, office		281.	Location (Street City or Town, S	and Numb ate)	er or Hur	al Route Number,
	Hospita 4 hours Funera ely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of	examinati	vledge, death ion and/or inv	occurred restigation,	at the tim	e, date an	d place, and th occurred a	due to the cause the time, date	e(s) and ma and place, a	inner as : and due !	stated. to the cause(s)
	To the Within 2. To the Complet	Mec	29b. Signature and title of certifier	and manner sta	ieu.		290	: License	number		29d.	Date signed	d (Month.	Day, Year)
	F≯Fö			. ~ ~ / .	^			17	37E5	4.		7/8	100	
			30. Name and address of person who		ath (Item	23a) (Type	Print)	1.7		-		, , _		1
							DTHE	TO	целы	MORV	LAND 2	1804		
	Sta	te	31. Date filed (Month, Day, Year)	7 (5.17) 32. Registra		ure D	·-			EHPHA I	and I I That from	une enter Test F	-	
	Registr	100	JUI 1 4 200	4 Sener	m	19	dos	ch	/					

Unneed :	**		partment of Health and	•	
onpena.	1	State #23a,27,per ME,G834,8/23/04 9 1. Decedent's Name (First, Middle, Last)	quincate of Death	2. Date of Dea	G. THITO OF DOGE
Physiciar /Medica	al	Makayla Boyd		July	05, 2004 13:21
Examine		4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Deal	th	4c. County of Death
Funeral	٥	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birt	th y, Year) 9. Birthplace (State or Fore Country)
Director		N/A 1□M 200F Yrs.	Months Days Hours Min.	May 3	y, Year) Country) MD
and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	J	10d. Inside City Lim
Marylan e-f ehow	ţō	MD W/A Bay	1 timore		1 ⊘ Yes 2 □ I
or 28e-f	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
s 23£		20 N. Port Street	71224		USA
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28e-f ehow or other treumstic event, the Medical Examinar must be notified at The December of the Complete Hygienes (1995).	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No of Yes, Give	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer Yes 2 No Specify: 	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
72 hours naturel', dical Ex		15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gr	cedent's Usual Occupation ive kind of work done during most of wo	rking	16b. Kind of Business/Industry
d 2 should be filed within 72 hours aft the and Mental Hygiene. 77 is marked other then "naturel", or treumatic event, the Medical Exam.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) N/A		N/A
2 should be fill and Mental Hy is marked oth reumatic even	To Be	17. Father's Name (First, Middle, Last) George Boyd	Tie	erra S	Maiden Sumame)
12 sho			ailing Address (Street and Number or Ri	ural Route Numbe	er, City or Town, State, Zip Code)
s 1 and 3 feeth of Health of them 27 other tr	-	Dierra Smith/mother 20b. Place of Dis	sposition (Name of	Date Date	20c. Location - City or Town, State
vermit. Pages 1 a Department of Hes mportent: if item iny injury or othe inge.		cemetery, ci	Ton Cen. Jy	13 2004	
permit. Pages Department of Importent: If i any injury or once.	Ì	21. Signature of Funeral Service Liceasee	22. Name and Address of Facility	eral Ser	Bultmore, MD wree, P. A. Amore MD 7 1201-1
9 G E 2 G		1 Attended	709 Tessien S	J. Bal	more MD Z 1201-1
cate be executed Examiner ithe burial-transit	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
	Me		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
uires that signed t ld be deti		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to the cause of death?
is certificate has been si director, page 2 should	Completed			24a. Was a autop: perfor	sy prior to completion of cause
or Attending Physicien: The law requires to after death. Director: After this certificate has been signe in by the funeral director, page 2 should be contributed.	1 0	25. Was case referred to medical examiner? 1 □ ★ es 2 □ No Hospital: 1 □ Inpatient 2 ★ EP/Outpati	Othor	ath (Check only or	ne) ence 6 □Other (Specify)
ding After fune	TION: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at		ow injury occurred
o the Hospitel or Attending P ithin 24 hours after death. o the Funerel Director: After t gripletely filled in by the funera Madizal Cartification.	Certifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (S. City or Town	treet and Number or Rural Route Number, n, State)
Hospi 24 hou Funer stely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de. 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred	e, and due to the corred at the time, d	ause(s) and manner as stated. late and place, and due to the cause(s)
To the To		29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
Deno		Joseph Trees MD	O.C.M.E.		July 6, 2004
186		30. Name and address of person who completed cause of high (Item 23a) (Typinos Na Z Greenberg MD 11	e, Print) 1 Penn Street, Bal	timore,	Maryland 21201
State Registrai	e		1 Penn Street, Bal	timore,	Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of	f Marylar		artment of <i>tificate o</i>	Health and If Death	Mental H	ygiene Reg. No		20110
	Physic	ian	1. Decedent's Name (First, Middle, L GLADYS BRINI						2. Date of D Month	Death Day	Year	3. Time of Death
	/Medi Exami	cal	4a. Facility Name (If not institution, gi	ve street and nun				, or Location of De	July_		004 County of Deat	3:37 A M
			Upper Chesapeake Med 5. Social Security Number 6.			. last birthday)	Be1	Air ar If Under 24 H	IS 0 Date of B		Harford	
	Funeral Director		245-42-8755	1 № M 2□F	73	Yrs.	Months Day		rs. 8. Date of 8 (Month, E	Day, Year)	Co	hplace (State or Foreign untry) th Carolina
	yland		Usual Residence of Decedent 10a. State 10b. County	-		ity, Town or Lo						10d. Inside City Limits
	the Mar 28a-f sl	ector	MD Harfor 10e. Street and Number	d 		Forest				10- 00	zen of What Co	1 □ Yes 2X No
	th with 1	ai Dir	2837 Sharon Road	, PO Box	711		10f. Zip Code 2105			Tog. Citi.	USA	untry?
23	21215-0036 within 72 hours after death with the Maryland jiene. Than "natural", or items 23e or 28a-1 show the Marical Examiner must be notified at the Marical Examiner must be notified at	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 21 Married	12. Was Dece Amed For	rces?	J.S. 13. V	Was Decedent of Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, White	
033	21215-0036 d within 72 hours aff gione. or than *natural; or the Medical Exam.	d by	3 Widowed 4 Divorced	1 M Yes If Yes, Giv Year or Da	ate 1950-5	3	I□Yes 2🗶N			į	Specify: W	nite
0	215-1 nin 72 t	plete	15. Decedent's E (Specify only highest given the state of	Education rade completed) College (1	-40r 5+)	16a. Deced (Give life. L	lent's Usual Oci kind of work do DO NOT use ret	cupation ne during most of w ired)	vorking	16b. Kir	nd of Business/	Industry
		Com	7			Masc	n Contr				nstruct	ion
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	M62 Illha 27 ts		19a Informant's Name/Relationship Frances E. Brine			19b. Mailin PO E	g Address (Stre SOX 711,	et and Number or 2837 Shar	Rural Route Num.	ber, City or F orest	Town, State, Z Hill, M	(ip Code) 21050
181			20a. Method of Disposition XXaurial 2 □ Cremation 3			cemetery, cren	sition (Name of natory or other p	ardens 7/1	Date 2/2004		cation - City or	
	Baltimo permit. Page Department of importent: If any injury or once.		*4 □Donation 5 □ Other (Spec 21. Sign ure Funeral Service Lice		01	22	. Name and Ade	dress of Facility				, PA 17314
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	Physician		Is mediate Cause (Final disease or condition resulting in death)		systo	5						Interval Between Onset and Death
	/Medical Examiner	ı		Due to (or as a consec (di 0	Pulmo	nary	Arrest	-			**
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18223	18760, cate be executed physicien and s the burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or as a consec			LUNG	Disea	JE.		10 415.
#		edicai		d. Kes	pirator	r Aci	dosis	-				
12	Box 6 eath certifi attending	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregnirth 2 Feta		Ectopic pregna	ncy		2	23d. Date of deli Month	very Day Year
	at the dea by the at	Physician/M	1 Yes 2 No 9 Unknown	4□Pregn: 9□Unkno	ant at time of o	death 5□	Other (specify)				WORL	Day rear
10	- 2 P B	b	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the ur	nderlying cause	given in Part I.		_		the cause of death?
Flachys	COLD w requir been s should	ieted							24a. Wa	•		topsy findings available
0	Ital Records, ien: The law requires trificate has been signe tor, page 2 should be o	Completed						·· ···································	pert	opsy formed? 2 No	prior to death? 1 ☐ Yes	ompletion of cause of
	Vital F sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		1			eath (Check only			
gar	on of ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date o	of Injury	ER/Outpatient 28b. Time of	t 3 2 DOA 28c. tr	Other: 4 Nursing	Home 5 Res 28d. Describe			ify)
<u> </u>	ISION (ttending F death. ctor: After y the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigate	on	h, Day Year)	Injury		vork? □Yes 2□No				
20	Division of Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	289. Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, stre fy)	et, factory, office	ce	28f. Location City or To	(Street and own, State)	d Number or Ru	ral Route Number,
B	Division To the Hospitet or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the	best of my knows of examination	owledge, death ation and/or inv	occurred at the estigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the To the Comple	Med	29b. Signature and title of certifier		iei stateu.			ense number			signed (Month	
	./		18491		<i></i>			8424		July	1-8.	2004
	h		30. Name and address of person who B-Pave Kh	. 8 .00	1001	m 23a) (Type, I	1 0.	d, Fall	ston	MD	2104	7.
	St	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature		,				

		Flease	State of Marylan				-	_	oie.
		1 - State	State of Marylan	-	rtificate of		vi c iliai ny	200	14 22150
		1. Decedent's Name (First, Middle, Las	r)	OC.		Dealii	2. Date of De	Reg. No U	3. Time of Death
Physic	cian		N BEAY	1			July	Day	Year 2004 0401M
/Med Exam		4a. Fecility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County	
Exam	mer	North Aruna	/!	tal	Glev	Burn.		K	7 A
Funera		5. Social Security Number 6. Se	7. Age Vyrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	Birthplace (State or Foreign Country)
Directo		523-56-9707	X ^M ^{2□ F} 58	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di May 22	, 1946	Colorado
pu ,		Usual Residence of Decedent 10a. State 10b. County	10e Cib	, Town or Lo	antine .				10d. Inside City Limits
anyla shov	5								1 ☐ Yes 2X No
he M	Director	MD Anne Aru	ndel Ga	ambri1	10f. Zip Code			10g. Citizen of W	
with 1	ä	2241 Misthaven La	ne		210	5/4		USA	mat Country!
ING X IX I 3-00.30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23a or 28a-f show event, the Marical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.			pecify Yes or No		- American Indian,
fter d	Ē	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 XYes 2 ☐ No			Hispanic Origin? (S pan, Mexican, Puert	o Rican, etc.)	Blac	k, White, etc.
within 72 hours after then "netural; or ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes ŽÆŽNo	Specify:		Specify	White
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thin 7	n pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	od)	9		
filed with Hygien other the	ပ်	12		Rese	archer	10.11.11	<i>(</i> =1		<u>f Defense</u>
and A	Be	17. Father's Name (First, Middle, Last)					de Juli	, Maiden Sumam	9)
aryica should nd Men marke	2	Glynn Allen Beard			411 (0)				0 7. 0
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event		19a. Informant's Name/Relationship (7 Yoshiko Beard (Wi				t and Number or Ru en Lane,			
~ L		20a. Method of Disposition			osition (Name of matory or other pla		Date		City or Town, State
Pages nent of nut: If it		XX Burial 2 Cremation 3 C	Memoval from State		matory or other pla Vet. Cei		-2004	Crorman	ille, MD
E - EE E		21. Signature of Funeral Service Light		2	2. Name and Addre	ess of Facility			ille, MD
Department of the part in the		173- 2.C	m		Hardesty	Funeral Ly Avenue	Home, P	.A.	21/01
		23a. Part1. Enter the disease, or comp shock, or heert failure. List only	olications that caused the death						Approximate
Physiciar		Immediate Cause (Final	one cause on each line.	1	1	1-1	. 11	100.00	Interval Between Onset and Death
/Medica	_	disease or condition resulting in death)	a. The to (or as a consequence)		dIAC.	// V. K.	YTEN	114	
Examine	r	and the second second	Hyterios	den	otic	HEAR	+ L	1509 51	2_
n =	ne -	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):)				
ocuted ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Hypery		100				
/ bu, e be executed /sician and e burial-transit	E	resulting in death) cast	Due to (or as a consequence	uence ot):					
- w - w	dical	•	d						
Geath certifical death certifical e attending phyd for use as th	Me	IF FEMALE:	23c. If yes, outcome of pregna	Incv				224 0-1	4 deli
BOX sath cer attendin for use	jan	in the past 12 months?	1 Live birth 2 Fetel	Ideath 3[Ectopic pregnance Other (specify)	у		Mor	a of delivery oth Day Year
	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	Ju., 50	_ Other (speeny) _		- TAX		
THECORDS, P.O. The law requires that the de sate has been signed by the a page 2 should be detached for	by Physician/Medi	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco use contr	bute to the cause of death?
dS puires n sign	Ď						10	Yes 2 🖔 o	3 Probably 4 Unknown
COLD w require been si should I	ete						24a. Was		Vere autopsy findings available
HeC he lav e has age 2	Completed						auto perfe	ormed? d	rior to completion of cause of eath? □ Yes 2□ No
VITAI HECOTOS, sicien: The law requires t certificate has been signe frector, page 2 should be o	a)	25. Was case referred to medical				26. Place of Dea			
OT VITAL Physicien: rthis certifica	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Ot	her: 4 🗌 Nursing H	ome 5 Res	idence 6 🗆 Othe	r (Specify)
9 Ph 19 Ph 16 th	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe	how injury occurre	ed
auth.	atic	2 ☐ Accident investigation			M 1]Yes 2 □No			
JIVISION OT I or Attending Phys after death. Director: After this in by the funeral di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office			(Street and Numbe wn, State)	or or Rural Route Number,
DIVISION OF VITAL INC. To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			1						
Hosp 4 hou Fune fely fil	Medical	(Check only 2 Medicel Exem	ysician: To the best of my kno niner: On the basis of examina						
thin 2 the mpler	Med	29b. Signature and title of certifier	and manner stated.	10011	/ 29c. Licen	se number		29d. Date signed	(Month, Day, Year)
		1/1000 1	J LED	ary	7	060	54	7/1	2/4
1	0	30. Name and address of person who	completed cause of death (for	23a) (Tunn	Print)		1	// '	(Month, Day, Year) 2/4 21035
Ì		William P	Janes, W		1095	- Am	erica	Ct.	21055
5	itate	31. Date filed (Month, Day, Year)	32. Registrar's Signa			1			
Regis		JUL 1 4 20	104 Deneral	D	ppour	2			

Alfred Buchanan 04-04445 DOS unpend item#23a-b,27,PER ME,G833,7/27/04eg
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3			For State Registrar	State of M	Maryland / Dep Ce	artment of I rtificate of			ental Hy	ygiene Reg. Né	1000	20	
	Physici	an	Decedent's Name (First, Middle, La	st)		rimouto or	Doutin		2. Date of D Month				ime of Death
	/Media	cal ,	ALFRED BU						July		2004	84	2 a ^M
	Examir	ier	4a. Facility Name (If not institution, given Maryland General		r)	4b. City, Town, o	timor			40	. County of De	eath	
2		4			Age (In yrs. last birthday				9 Data of B	ieth	N/A	National Co.	
3	Funeral Director		216-42-6062	XXM 2□F	60 Yrs.	Months Days	Hours	Min.	8. Date of B (Month, D AUG.	ay, Year)		Country) ARYLA	State or Foreign
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	acation						104 1	id- 05 11 1
	faryla sho	ō										1	ide City Limits Yes 2 □ No
	the N	Director	MARYLAND N/A 10e. Street and Number	-,	BAL	TIMORE 10f. Zip Code				10- 0	izen of What		
	with se or	Ö		7, 1777		,	017					Country?	
	leath ns 23	era	2136 DRUIDHILL 11. Marital Status	12. Was Deceden	nt Ever in U.S. 13.		217 Hispanic Ori	gin? (Spe	cify Yes or N		.S.A. 14. Race - Ar	nerican Indi	ian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 Is marked other than "natural", or Itams 23s or 28s-f show other traumatic avant. It a Modical Exertire must be notified at	by Funeral	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	s?]No	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		i, Puèrto I	Rican, etc.)		Black, Wi		шт,
8	"natural",	ed	15. Decedent's E		03/00	dent's Usual Occup	nation			16h K	ind of Busines		
Maryland 21215-0036	n "ne	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done DO NOT use retire	during mos	t of workir	ng	100.10	ind of busines	symuustiy	
212	d within piene. r than " If e Mes	шо	Elementary/Secondary (0-12) 12th grade	College (1-4or		nknown					N/A		
Þ	e filed of ha	BeC	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle	e, Maiden			
<u>a</u>	Ald be Alenta Alenta rikad tic av	To B	ALFRED A BURCHAI	NAN SR.			MAR	YLI	BUCHAN	AN			
ary	shot and N s ma		19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street					or Town, State	, Zip Code)	
Σ	1 and 2 should be filed withir Health and Mental Hygiene. Iem 27 Is markad othar than othar traumatic avant. It s. M.		Betty Buchanan/S:	ister	2136	Druid Hi	11 Av	e., I	Baltimo	ore,	Marvla	nd 21	217
Se	of He		20a. Method of Disposition	7.5	20b. Place of Dispo	osition (Name of matory or other pla		D	ate		cation - City		
<u>Ĕ</u>	Page nent ant: It		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci		GARRISON			07-16	5-04	OWI	NGS MI	LLS.	MARYLAN
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		21. Signature of Funeral Service Lice	ised.		2. Name and Addre VILLIAM C L206 W NO	BROW	N COM	MUNIT				
			23a. Pani. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death. Do not en	er the mode of dyin	ng, such as	cardiac or	r respiratory a	arrest,		Appro	ximate al Between
68760,	Physician / Medical Examiner bhysician and bhysician and sthe prujal-transit	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Due to (or a c.	s of the Live s a consequence of): Abuse s a consequence of): s a consequence of):	r						Onset	and Death
P.O. Box 687	Attanding Physician: The law requires that the death certificate or death. r death. actor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	4□Pregnant a 9□ Unknown	2 ☐ Fétal déath 3 ☐ at time of death 5 ☐	Ectopic pregnanc					23d. Date of d Month	elivery Day	Year
	uires th signed Id be de	by	Part II. Other significant conditions	ontributing to death:	but not resulting in the u	nderlying cause giv	ren in Part I.				ise contribute ≰No 3□ F		
Division of Vital Records,	e law req has beer je 2 shou	Completed							24a. Was	psy	24b. Were a	autopsy find	ings available
=	The cate h	Col							perfo Yes	ormed? 2 □ No	death?		
Zit.	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hamital			-		(Check only				
of	Physical direction	2	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpat			4 🗀 1401				6 □Other (Sp	ecity)	
L C	ding f	lon	1 Matural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Time o ay Year) Injury	Wor			8d. Describe	how injur	y occurred		
Si	ttandideath	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e Oce Diese of Ir	njury - At home, farm, sti		Yes 2 🗆 N		Of Leasting (Ctuant			
<u>S</u>	lor A after Dirac	Certification:	4 ☐ Homicide determined	building, e	etc. (Specify)	eer, ractory, onice		2	City or To	wn. State	d Number or F)	turar Houre	Number,
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Pt (Check only one)	niner: On the basis	t of my knowledge, deat of examination and/or in	n occurred at the tir	me, date and opinion, deat	d place, a	nd due to the d at the time,	cause(s)	and manner a	as stated.	ıse(s)
	thin 2	Mec	29b. Signature and type of certifier	and manner s	stated.	29c. Licens	e number			29d Dat	e signed (Mor	th Day Ve	21
	⊢ 3 - 8 -		* SICAN	M		OCME					8, 20		/
			30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)	CI		D-7:			7 1	21201
_				42		111 LG	in St	eet,	Balti	unore	, Mary	Tand 7	21201
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 4 21	1	trar's Signature								

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					aryiand / Dep	ertificate d		•	Reg. No ?	ΠL	22152
	Physic	ian	1. Decedent's Name (First, Middle, L					2. Date of De Month	ath Day	Year	3. Time of Death
,	/Medi		RUTH	WALLAC	E CL	ARKE	. 1	July	7	2004	0530
A ^d	Exami	ner	4a. Facility Name (If not institution, g		· · · · · ·			or Location of Death	4c. Count	y of Death	
			Alice Byrd Tawe 5. Social Security Number 6.			/) If Under 1 Ye	Crisf			Somer	
	Funeral Director		216-14-2461 Usual Residence of Decedent	1 M 2 K F	e (In yrs. last birthda) 97 Yrs.	Months Day			y, Year) 4, 1906	9. Birthpla Country Virgi	ice (State or Foreign y) nia
1	and ow		10a. State 10b. County	<u>-</u>	10c. City, Town or I	ocation		·		100	d. Inside City Limits
	Many -1 sh	ō	Virginia Accom	ack		Ψэг	ngier				1 X Yes 2 □ No
ģ	4.28a	irec	10e. Street and Number	ac.r.	1	10f. Zip Code			10g. Citizen of	What Countr	y?
1	138 o	E C	16226 Main Ri	dge Road			23440		USA	4	
Maryland 21215-0020	within 72 nouts after death with the Maryland ene. Then "netural", or items 23e or 28e-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:	Ever in U,S. 13	. Was Decedent of If Yes, specify C 1 ☐ Yes 2 🛣 N		(Specify Yes or No erto Rican, etc.)	14. Rad Bla Specif	ce - Americar ck, White, et y: Whi	c.
5 3	etura	e	15. Decedent's E	ducation	16a. Dec	edent's Usual Occ	cupation		16b. Kind of B	usiness/Indu	strv
בונד היים		Completed	(Specify only highest g. Elementary/Secondary (0-12)	ade com <i>pleted)</i> College (1-4or 5	(Giv	e kind of work do: DO NOT use ret	cupation ne during most of w ired)	rorking	Accomad		•
7	giene giene	E O	12	5+	,	School	Teacher		School		*
ם פ	al Hy	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's N	ame (First, Middle,	Maiden Surnar	ne)	
ya Ş	Ment Ment arkec	2	Sidney S. Wallac				Dollie	W. Dise			
Jar S	is m		19a. Informant's Name/Relationship					Ru <i>ral R</i> oute Numbe			'ode)
ם ב	m 27		Wallace Pruitt_() 20a. Method of Disposition	Nephew)	P.O. 20b. Place of Disp	Box 183	3 - Tangi	er, Virgi			
	or of		1∑ Burial 2 ☐ Cremation 3 l		cemerery, cri	ematory or other p	vace)	Date	20c. Location	-	
	rtmer rtant: njury	1	4 □ Donation 5 □ Other (Spec		Whatcoat Un			ry 7/9/04	Snow Hi	lll, Ma	aryland
Baltimore,	points. Toges rank a should be filed within 72 no Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture eny injury or other treumatic event, the Medical once.		21. Signature of Funeral Service Lice Mary Beth Br	1 lolla 5	crutt		7 & Sons :	Funeral H et - Cris		MD 219	217
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caused	the death. Do not en	nter the mode of d	lying, such as cardi	ac or respiratory ar	rest,		oproximate nterval Between
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, and a	end al-trar	Xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a conse	quence of):					
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Investigation of VIII necolds, P.O. Box 68/60, or Attending Physicien: The law requires that the death certificate he executed	s been signed by the attendi	Completed						24a. Was a perfor		availa	autopsy findings able prior to eletion of cause ath?
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, e	certificate irector, pa	BeC	25. Was case referred to medical				26. Place of De	eath (Check only or			
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al or Att	s after death Il Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, si . <i>(Specify)</i>	reet, factory, offic	е	28f. Location (S City or Town		er or Rural A	oute Number,
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To th	Vithir comp	Me	29b. Signature and title of certifier			29c. Lice	nse number	2	9d. Date signe	d (Month, Da	y, Year)
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•	X		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type		<u> </u>			, /	
	4.7		Vijay Karumbu	nathan, M.I	о 201 н	all High	way - Cr	sfield,	Marvlan	d 2181	7
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1 .	,		1		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 per ff 6845 7-15-05 tas State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #19a PER FH G833 Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** FLOYD DUDLEY :25 A M 2004 Durl /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number), Examiner ALT: MORE VAMEDICAL CENTER A BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 115KM 2 F 226-14-154 VA 84 Director 9-5-1919 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28e-f show other treumetic event, the Medical Examiner must be notified at MD NIA 1 XYes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò GWYNN AVENUE 21229 429 USA or Items 23e by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: BLACK Specify: 3 Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene Important: If item 27 is marked other then "naturany or other treumetic event 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL NA STEELW DRKER 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FANNIE CHAPMAN SILAS DUDIEY CHENDOLYN PRESBURRY Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 DORCHESTER ROAD BALTO ND 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 07/19/2004 Crownsville, MD CROWNSVILLE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
VAUGHNC, GREENE FUNERAL SERVICES 215
5151 BALTIMORE NATIONAL PIKE, BALTO MD 21220 2 Mar 23a. Part1. Enter the owease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PyLMONAR. Immediate Cause (Final 4RPC4LOSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit and Due to (or as a consequence of): the attending physician Box 68760 Physiclan/Medlcal IF FEMALE . If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury a Hospital or Attending Pl 24 hours after death. 5 Funeral Director: After th 28d. Describe how injury occurred Certification: 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 840 ∞ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALBERT MD LONGREENE STREET BALKINURE. MichAeL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 4 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 11-05 AM PHYLLIS J. DIX 12 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MORE BALT MG to spi TVH 73M If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | NOV 1, 1946 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 1 ☐ M 2 🔀 F 57 MARYLAND 219-50-5140 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "natural", or Itams 23a or 28e-f show traumetic evant, I'm Madical Examiner must be natified at 1 Yes 2 □ No Director MARYLAND NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4913 ST. GEMMA ROAD 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. lited within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: AFRICAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☑ Widowed 4 ☐ Divorced AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 ŇΑ NURSING ASSISTANT NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Is marked ot Be LORENZO HILL SARAH HILL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pages 1 and 2 si ment of Health an ant: If itam 27 Is r ury or othar traur BALTIMORE, MARYLAND 21229 DEBORAH D. CHASE 4913 ST. GEMMA RD DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State rtment: JUL17, 2004 GLEN BURNIE, MARYLAND CEDAR HILL ' 4 ☐ Donation 5 ☐ Other (Specify) njury permit.
Departmitmports
any nju 22. Name and Address of Facility WYLIE FUNERAL HOME P.A. 21. Signature of Funeral Service Lucensee † 638 N. GILMOR ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nound Hours disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ ¥es 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has 2 No 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After or Attanding Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitel within 24 hours at To the Funaral Completely filled in 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

MEDICAL RESIDENI

Osei-Boemil

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 1 4 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav :30 Pi FARLE DORUTHU D)who /Medical 4b. City, Town, or Location of Death Faqility Name (If not institution, give street and number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗹 F Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e eny injury or other treumatic event, It e Mandral Examples 1 and 2. 13. Was Decedent of If Yes, specify Cu 14. Race -American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, Wyor Town, State, Zip Code) Drive, U 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 ☐ Cremation * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ugha C Greene F 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** adomo (in anoma /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed signed by the attending physicien and resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🗌 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy prior to completion death? 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes Certification; To 21X No this c 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ate of Injury (Month, Day Year) 27. Manner of Doath 28b. Time of injury at Work? 28d. Describe how injury occurred After 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year))Wy 2004

State Registrar 31. Date filed (Manual Control of the Control of th

ess of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician FURNARI** SAMUEL M. JULY 2004 11:55 A.M 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MORNINGSIDE HOUSE OF SATYR HILL BALTIMORE PARKVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**反**M 2□F Months Director 3/21/1932 MARYLAND 218-26-5765 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or Items 23e or 28e-f show traumatic event, the Medical Exert event and be notified at 10d. Inside City Limits Director 1 Tyes 2 XNo MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6004 FALLS ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Affricas: 1 MYes 2 - No If Yes, Give Year or Dates: KOREAN 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed by 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) STATE OF MARYLAND and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FINANCE MANAGER DEPT. OF HEALTH 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be LOUISE FURNARI ROSE BREGULIO 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 6004 FALLS ROAD BALTIMORE, MD MICHAEL FURNARI SON other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ξ ö permit. Page Department of Importent: If eny injury or once. ¹ 4 ☐ Donation 5 Other (Specify) DULANEY CALLEY MEM. GAR. 7/15/04 COCKEYSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee S521 LOCH RAVEN BLVD. TOWSON, MD 21286 and Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ENMOS Worvow disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Examiner Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate nevenim 2 🗆 No 2 X No 1 Yes 1 Yes Attending Physician: 25. Was case referred to medic examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗀 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō Technifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 410201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5000 Samartan 1405p / P.O.B., Ste 303 och Raven Blud Balto: MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State backs Registrar 1 4 2004

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P.O.

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8/2/04 TT

12 PARTH CR34

Reg. Ng. 1- Stata Amend item #12 perFH,G834 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year July 10 2004 5:00 a ^м Bowers Frve /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2 Shadowbrook Court Baltimore County <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Min Yrs. Director 214 12 8618 83 Martinsburg, W. Va. June 29 1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, Ite Medical Examinar must be notified at 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 ☐ No Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Shadowbrook Court. 21237 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 ₹ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is 1 and 2 should be fill Health and Mental H tam 27 is marked oth Be Jesse G Frve Maude K Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis G Frye (Brother) 733 Treys Dr. Winchester, Vinginia 22601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. July 14 2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Physician Metastate caecinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, by Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be di seale 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a To tha Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/ i VA DFG FER, MD (0918 LINGE

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 1 4 2004

32. Registrar's Signature

Read

Balkmore, maryland 21237

			1 - For State of Ma	aryland		artment			ınd Me	ntal Hygie	2001	22150
	a	#5	Decedent's Name (First, Middle, Last)						2.	Date of Death	W (/ m)	3. Time of Death
	Physici /Medic		RUSSELL, HOUGHTON							Month O 7	08 Zoo4	0910AM
	Examir		4a. Facility Name (If not institution, give street and number)	DICAL		4b. City, To					4c. County of Death	
		ď.	UNIVERSITY OF MARYLAND.	CEN	TER				MD			
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 124 M 2 F	e (In yrs. las 34	st birtnoay) Yrs.	Months (Hours	Min. 8.	Date of Birth (Month, Day, Ye Jan. 23,	9. Birthpl	ace (State or Foreign try) W York
			Usual Residence of Decedent							, aii. 2),	1770 NE	w fork
	nylan show	_	10a. State 10b. County	10c. City,	Town or Lo	cation					10	Od. Inside City Limits
	ith the Marylar or 28e-1 show	Director	Maryland Frederick			Union		dge				1 ☐ Yes 2 🕍No
	with the	Dir	10e. Street and Number 11716 Bunker Hill Ct.			10f. Zip C				10g.	Citizen of What Count	try?
	eath w	Funeral		Ever in U.S.	13 1	Vas Deceder	2179		in? (Specif	Vac or No.	U. S.A.	an Indian
(0	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-1 show offical Examination and be notified at	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 1	No.	. 10.				Puerto Ric	y Yes or No- an, etc.)	Black, White, e	
03	rel', o	i by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		,	☐Yes 2	No E	Specify:			Specify: Wh	ite
5-0	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give	ent's Usual (kind of work OO NOT use	Occupation done dur	on ring most	of working	16b	. Kind of Business/Ind	ustry
121	filed within Hygiene. sthar then "	dmo	Elementary/Secondary (0-12) College (1-4or 5	i+)	inte. L	mecha					CORVOYOR	
d 2	filed with Hygiene. other ther ant, It e N		17. Father's Name (First, Middle, Last)	1				8. Mother	's Name (F	irst, Middle, Maid	conveyor	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-1 show other treumatic event, If a Mcdical Examinar must be notified at	To Be	James Russell Houghton						Kar	en Jean	Higley	
lary	2 short and N is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (S	Street and	d Number			ty or Town, State, Zip	Code)
	1 and Health Health Sther tr		Rebecca Houghton/wife			6 Bunk		1111			Bridge, MI	21791
Baltimore,	8°= 5		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	сеп	netery, cren	sition (Name natory or othe	er place)		Date	200	. Location - City or Tov	
Ë	Department Importent: eny injury		'4 □ Donation 5 □ Other (Specify)	All	Count	y Crem	atio	n 7	/10/2	004 S	kesville,	MD
Ba	permit. Departm Importe eny inju		21. Signature of Funeral Service Licensee	len	6	E. Br	address	of Facility			eral Home	
	-		23a. Part1. Enter the disease, or complications that caused	the death.							e, MD 21791	Approximate
	e Pnysician		snock, or near failure. List only one cause on each in	ne.								Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a			HL.	HEV.	NOR	CHA	6E		
	Examiner		Sequentially list conditions.									
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Orderlying Cause (Disease or injury	a consequer	nce of):						-	
	xecut and	Examine	that initiated events resulting in death) Last Due to (or as	a conseque	nce of):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit		d		ŕ							
9	tificat ng phy as the	ledic										
Вох	eath certific attending p	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth			Ectopic preg	nancv				23d. Date of deliver	•
0.	at the dea by the at stached fo	/sicl	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	time of deat	th 5 🗌	Other (speci	fy)				Month [Day Year
α.	that the		Part II. Other significant conditions contributing to death be	ut not resulti	ing in the un	derlying caus	e riven	in Part I	-31	23e Did tohaco	o use cantribute to the	cause of death?
ds,	uires sign	d by				,g	giroin			1 ☐ Yes	_/	bly 4 Dunknown
00	w requir baen si should	lete								24a. Was an	24h Were autoni	sy findings available
Vital Record	Tha larate has	ompleted								autopsy performed	prior to com death?	pletion of cause of
ita		Se C	25. Was case referred to medical				21	6. Place o	of Death /C	1 Yes 2/2	No 1 ☐ Yes 2	!□ No
of V	dis dis	To B	examiner? 1 ☐ Yes 2☐ No Hospital: 1☐ Inpatie	nt 2□EF	NOutpatient	3□ DOA	Other:	4 🗌 Nurs	sing Home	5 Residence	6 ☐Other (Specify)	
	ng fter ine	on:	27. Manner of Death 28a. Date of Injur 1 Natural 5 ☐ Pending (Month, Day	y Year) 28	8b. Time of Injury		Injury at Work?			Describe how in	jury occurred	
Sio	Attending or death. actor: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be	At h	. (M		s 2□No		l ===ti== (04 · · · ·		
Division	7 e i i	ertif	4 Homicide determined 28e. Place of Inju- building, etc	. (Specify)	e, iaim, sire	et, ractory, o	псе		201.	City or Town, St	and Number or Rural i ate)	Houte Number,
	spital or hours afte ineral Dir y filled in	alc	29a. Certifier 12 Certifying Physician: To the best of	of my knowle	edge, death	occurred at t	he time,	date and	place, and	due to the cause	(s) and manner as sta	ted.
	To the Hospital or within 24 hours af To the Funeral D completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination	n and/or inv	estigation, in	my opini	ion, death	occurred a	t the time, date a	and place, and due to t	he cause(s)
	To with	Σ	29b. Signature and title of certifier	1	N.D.		icense ni	_		29d. I	Date signed (Month, Da	ay, Year)
7	σ_i		(June)			_ 1	PI:	, ,	24	+	18/04	
	\ 		30. Name and address of person who completed Seusa 31 de CYNTHA TUNG UNIVE			MARYL	S. G	reen Mé	e St.	Baltin TC SYS	nore, MD 21	201
•	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 1 4 2004 32. Registra	ar's Signatur	4	par.	4					

		•	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of I rtificate of		nd Mental Hy	giene Reg. No.	04	22159
	Physici		1. Decedent's Name (First, Middle, Last, William Du		ond, Sr.		-	2. Date of De Month July	9, 2004	Year	3. Time of Death 10:30 PM
	/Medio	er	4a. Facility Name (If not institution, give Buckinghams Choic	e Health			stown	Death	4c. Count	ederio	
	Funeral Director			M 2□F 7. A9	e (In yrs. last birthday) 81 Yrs.	Months Days		Min. 8. Date of Bi (Month, Doct. 6	, 1922	Mary	place (State or Foreign ntn) y Land
	e Marylend e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	ζ	10c. City, Town or Lo					1	lod. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	i Dire	10e. Street and Number 3200 Bakers Circ	Le, Apt.	I 135	10f. Zip Code 21710			10g. Citizen of U.S.A.	What Cour	ntry?
980	toges 1 and 2 should be filed within 72 hours efter deeth with the Marylend it of Heelih and Mental Hyglene. If Item 27 is marked other than "naturel", or Items 23a or 28e-f show or other freumatic event, the Madreal Examinar must be maillised at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent	Ever in U.S. 13.	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 🛣 No		n? (Specify Yes or N Puerto Rican, etc.)	Bla	ce - Americ ick, White, fy: Whi	etc.
21215-0036	within 72 ho ene. than "natur the Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5 +5	(Give	dent's Usual Occu kind of work done DO NOT use retire fied Pub	during most o		16b. Kind of E		dustry
Maryland 2	12 should be filed within? h and Mental Hygiene. 7 is marked other than " freumatic event, the Med	To Be Co	17. Father's Name (First, Middle, Last) Charles L.	-			18. Mother	s Name (First, Middle ary Yellot	, Maiden Sumai t	me)	
Mar	nd 2 sho alth and 27 Is ma r treum		Mrs. Louise W. Har					or Rural Route Numb Apt. I 1.			
Baltimore,	permit. Pages 1 and 2: Department of Heelth ar Importent: If Item 27 is any Injury or other treu		20a. Method of Disposition 14 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Dispo cometery, cre Mount Olive	matory or other pla	Ju	nly 13, 20	20c. Location 4 Fred	•	
Balt	permit. Departr Importe any Inji		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Drey	MUU255	_106_Eas	t Churc	sford PA F h St., Fr	<u>ederick,</u>	Home MD 2	
8760,	rate be executed /Medical Examiner und physicien and the burial-transit	dicai Examiner	shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	CANT	JZAV G	WLAN DI	SEASE		Approximate Interval Between Onset and Death
P.O. Box 68	ath certific attending p for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey		I	ate of delive	ery Day Year
	n requires that the di been signed by the should be detached	ed by Ph	Part II. Other significant conditions co		out not resulting in the u	underlying cause g	ven in Part I.		tobacco use con		ne cause of death?
Il Records,	The law ate has b page 2 si	Completed						24a. Was auto perf 1 □ Yes		prior to cor death?	psy findings available mpletion of cause of
Vita	Physicien: The this certificate aldirector, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∑√No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DOA O1	han	of Death (Check only sing Home 5 Res		ner (Snecifi	iv)
Division of Vital	fter		27. Manner of Death 1	28a. Date of Inju (Month, Da		of 28c. Inju		28d. Describe	how injury occur		,
Divis	To the Hospitel or Attendii within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Rura	al Route Number,
	Hosp 24 hou Fune Fune letely fill	ledicai	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best ner: On the basis o and manner st	of my knowledge, deat of examination and/or in ated.	th occurred at the to estigation, in my	ime, date and opinion, death	place, and due to the noccurred at the time	cause(s) and m , date and place,	anner as st and due to	rated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				se number		29d. Date signe		
	TI		30. Name and address of person who c	ompleted cause of c	death (Item 23a) (Type,		.3191	_	July	12, 2	<u>1004</u>
	/ "		JULID MENUC	41,00	1564 01		OWN	Pius Fr	ZDERILL	i, mi	21702
	Sta Regist	ate *	JUL 1 4 2004		rar's Signature مُنْفُرُنُونُ	board					

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar		artment of Health and Mertificate of Death	Reg.		2160
ician	Decedent's Name (First, Middle, La	1 - 0 -			Day Year	ithe of Death
dical	PRESTON T.		4h City Tours and assting of Death			:55 P M
niner	4a. Facility Name (If not institution, gives		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
al	5. Social Security Number 6. S	Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
r	210 20 6010	10XM 20 F LOG Yrs.	Months Days Hours Min.	(Month, Day, Year DS 18	1935 Country	MD
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d los	side City Limits
tor	MD BALTI	MORE BALTI	More			∃Yes 2⊠No
Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?	
a D	7872 CORNERS	STONE WAY	21244		USA	
nner	11. Marital Status	Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - American Ind Black, White, etc.	lian,
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: DLAC	K
ted	15. Decedent's E	ducation 16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry	
Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-40r 5+)	e kind of work done during most of workin DO NOT use retired)			
Con	12th grade		ous Driver		Transporta	HION
To Be	17. Father's Name (First, Middle, Last		18. Mother's Name			
2	19a. Informant's Name/Relationship		ing Address (Street and Number or Rural	NA HA		1
			72 Cornerstone M			
1 8	20a. Method of Disposition	20b. Place of Disp	osition (Name of Da	ate 20c.	Location - City or Town, St.	tate
	1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	Hemoval from State	UTUS 07/17	104 I	BALTIMORE,	MD
	21. Signature of Funeral Service Lice	nsete 2	2. Name and Address of Facility VAUGHN C. GREEN			
	1 Vough CZ		5151 BAUTIMORE NA	HIONAL 1	PIKE BALTO 1	4D 2122
	snock, or neart failure. List only				Interv	oximate val Between et and Death
	Immediate Cause (Final disease or condition resulting in death)		ON CANCER TO LL	wcs	011301	- Land Dodain
	1	Due to (or as a consequence of):				
Jec	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):				
amlu	Cause (Disease or injury that initiated events	C				
ñ	resulting in death) Last	Due to (or as a consequence of):				
dlca		_ d				
Physiclan/Medical	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery	
clar	23b. Was decedent pregnant in the past 12 months?	4☐Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day	Year
hys	9 Unknown	9□ Unknown				
by P	Part II. Other significant conditions	contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the caus	
				1 🗆 Yes	2 No 3 Probably	4 Unknown
Completed				24a. Was an autopsy	24b. Were autopsy find prior to completion	dings available in of cause of
Con				performed?		0
Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death			
- T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ★ npatient 2 ☐ ER/Outpatie	nt 3 DOA 4 Nursing Hom	e 5 Residence 3d. Describe how in	6 Other (Specify)	
itlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		july cocurred	
Certification;	3 Suicide 6 Could not b	e 28e. Place of Injury - At home, farm, st			and Number or Rural Route	3 Number,
Cert		building, etc. (Specify)		City or Town, Sta		
edical	Check only 2 Medical Exal	nysicien: To the best of my knowledge, dear miner: On the basis of examination and/or in	th occurred at the time, date and place, an	nd due to the cause d at the time, date a	(s) and manner as stated. and place, and due to the ca	iuse(s)
0	one)	and manner stated.				
¥e	29b. Signature and title of pertifier		29c. License number	29d F	Date signed (Month, Day, Ye	98()

State Registrar

5

JUL 1 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAL HOSPITAL OF BALTIMORE, 2401 W.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

RES-000

W. BELVIDERE, BALTIMORE

JULY 11, 2004

		ı	For State	State of Maryland		rtment of F		_	giene Reg. No	20161
	Ohusisi		Registrar 1. Decedent's Name (First, Middle, Last				Doutin	2. Date of De		3. Time of Death
	Physici /Medio	al	4a. Facility Name (If not institution, give		awk		r Location of Deat	July	4c. County of Dea	06:21 AM
	Examir	er	11 4 4 44	em Hospi	tal	Bal	timo		40. County of Dea	41
	Funeral Director		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	 8. Date of Bir 	th 9. Bin Co	thplace (State or Foreign nuntry)
	Maryland f show led at	or	10a. State 10b. County	10c. City	, Town or Loca	ation or e				10d. Inside City Limits 1 Yes 2 □ No
	or 28a-	Director	10e. Street and Number	2	allin	10f. Zip Code			10g. Citizen of What Co	puntry?
	s 23a		501 E 4/15+	St. 12. Was Decedent Ever in U.S	C 142 W	215	218		21. S.	
920	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show saftest Examiling the multihed at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)	Black, Whit	
21215-0036		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give ki	O NOT use retired	during most of wo d)	rking	16b. Kind of Business	,
1d 21	filed Hygi ther	Be Cor	12 Fh 17. Father's Name (First, Middle, Last)			600		me (First, Middle	Maiden Sumame)	
Maryland			UNKNOWN				UnKno	wn		
Mar			19a. Informant's Name/Relationship (Se ddler	19b. Mailing				er, City or Town, State, 2	, ,
Baltimore,	ges 1 and t of Healt If item 2 or other 1		20a. Method of Disposition	20h PI	lace of Disposi emetery, crema	tion (Name of		Date	20a Logation City or	Tours Clots
Iţim	Pa Int:		`4 Donation 5 Other (Specification)	on Ga	VC:50	nfore	st 7-	14-04	OWings	m://s mD.
Ba	permit. Departr Imports any inji		21. Signature of Funeral Service Licer	21.2/2-	20	esley C	hun's	Sh F. +	7. 3alto Mi	21231
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the death one cause on each line.	n. Do not enter					Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. The to (or as a consequ	uence of):					
	Examiner	5	Sequentially list conditions,	b. Renal +AILU	lke					
8760,	The law requires that the death certificate be executed that been signed by the attending physician and toge? should be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any leading to inniversate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence d.						
9	ntificating physics as the	Media	IF FEMALE:							
.O. Box	at the death certific by the attending pi tached for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 DE	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
٥	w requires that I been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the unc	derlying cause giv	en in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pr	٠.
Records,	The law re ate has bee page 2 sho	Completed						24a. Was autop perfo	an 24b. Were at prior to death? 28.No 1 \(\text{Yes} \)	itopsy findings available completion of cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hamital		C44	The second secon	ath (Check only o	one)	
of	Phya this ral dii	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur	y at		dence 6 Other (Spe how injury occurred	cify)
Division	Atten	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		me, farm, stree		703 2 2 100	28f. Location (: City or Tox	Street and Number or Rown, State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar	ysician: To the best of my know niner: On the basis of examinati and manner stated.	wledge, death dition and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	110		29c. Licens	e number		29d. Date signed (Mont	h, Day, Year)
•			Joulyn Henes			-	24389	16-62	July 6 20	0014
			30. Name and address of person who Jocelyn Hines 201	completed cause of death (Item E University PAR			RE. MAR	YLAND :	21218	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signat		2				

Arthur Jackson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unknown 04-218 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04-04029 Certificate of Death DOS 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Jackson Arthur June 19, 2004 400 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Hospital Center Cheverly Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1935) | Min. | March 2,1950 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Yrs Washington, DC 54 **Director** 578-66-7648 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b Count 10d. Inside City Limits or than "natural", or Items 23c or 28e-f show the Medical Ever fractimust be cottling at 1 Yes 2 □ No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 USA 1204 Shepherd Street, N.W. filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify. Black. 3 Widowed 4 XDivorced Year or Dates: 1969 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Carpenter 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked otl Marjorie McRay Arthur Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 1204 Shepherd St., NW, Washington, DC 20011 Marjorie McRay - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Quantico National Cem 7/16/04 Triangle, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Avenue, NW, Washington, DC 20011 tatterne 6. Monigoneu 23a. Part1. Enter the disease, or complications that caused the Hath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Abdo men **Physician** Wound *Yurshot* disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed as the burial-trans Due to (or as a consequence of): Physician/Medical esn s IF FEMALE If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an page 2 autopsy performed? ate 1X Yes 2□ No Physicien: 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🕱 DOA 2 1X Yes his 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 1 ☐ Yes 2 🗖 No AM subject was death. 03/4 investigation 2 Accident 6/19/04 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 578 Sidewalk 124 hours at ne Funerei D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 19, 2004 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature 31. Date filed (Loot) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 JUTY 7, **Physician** 6:15 p M MICHAEL DAVID JONES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 15643 Deer Lodge Circle Hagerstown Washington If Under 1 Year | If Under 24 Hrs. June 13,1965 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Hours 39 Pennsylvania 219-92-8825 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Marvland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 15643 Deer Lodge Circle 21740 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No þ Specify: White 3 Widowed 4 Divorced Year or Dates: "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Desk Clerk 11 Motel permit. Pages 1 and 2 should be file Department of Health and Mental Hyu Important: If Item 27 Is marked other eny injury or other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be G. Edwin Jones Elizabeth Linda Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15643 Deer Lodge Circle, Hagerstown, Md. 21740 Kelly R. Kennedy Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07-12-04 Rose Hill Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ^{22. Name and Address of Facility} Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, R. hoel Br. Md. 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Small resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by å Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 28 No 2 🗀 No certificate 1 Yes 1 TYAS // after dear...
//al Director: After this ve...
// in by the funeral director, p. Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 10 within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) Name and address of pers 2. Registrar's Signature State 1 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Billy Lovette July Eugene 08 2004 19:48 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Towson
If Under 1 Year
Months Days Greater Baltimore Medical Center Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Ye Birthplace (State or Foreign Country) Sex ¥ M 2 □ F **Funeral** Months North Carolina 72 244-40-3291 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County id 2 should be filed within 72 hours after death with the Marylan thit and Mental Hygiene. 27 is marked other than "natural", or Items 23s or 28s-f show traumatic event. If a Medical Exerting or mark be coulded as traumatic event. 1 ☐ Yes 2X No Director Maryland | Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21085 802 Barrys Lane by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🎇 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Equipment Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineering Technician Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fi ment of Health and Mental F (ant: If item 27 is marked ot Blackburn Walter Eugene Lovette Blanche Ethel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 802 Barrys Lane, Joppa, Maryland 21085 Reba Carol Lovette - Wife othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department c Important: if eny injury or once. Bel Air Mem. Gardens 7/12/04 Bel Air, Maryland * 4 □ Donation 5 □ Other (Specify) Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multior an Failure disease or condition resulting in death) 2 days /Medical Due to (or as a consequence of): **Examiner** 6 months Acute myelogenous leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed burial-transil resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy Year Month Day in the past 12 months? ő 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has certificate 1 ¥ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Sinpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2**X** No 2 1 Tes his 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: Division or Attending 1 Natural 5 Pending investigation thours after death.

-unerat Director: After the function of t 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1년 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 07/09/2004 D38352 who completed cause of death (Item 28a) (Type, Print) 30. Name and address of person 57U1 15. Culture Strate Tollivore Up Schmartz, GLAC 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JUL 1 4 2004 Registrar

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land 21215-0036

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Baltimore,

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М			For Unpend Item #2531; 27 Maryland, Penartment of Health and State Registrar Certificate of Death	ental Hygi	ene	22165
	Physici		1. Decedent's Name (First, Middle, Last) Pufus icus (Sov	2. Date of Death	Da 2004 Year	3. Time of Death 4:25 P _M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
3937	Funeral Director		5. Social Security Number 6. Sex 12 - 84 - 1906 12 M 2 F 7. Age (In yrs. last birthday) Yrs. Hours Min. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthy	place (State or Foreign ntry)
116	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits Yes 2 ☐ No
	with the fa or 28a-	i Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
9	be filed within 72 hours after death with the Maryland stal Hygiene. So other than "natural, or itema 23a or 28a-1 show event, the Medical Examinational te rediffied at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates:	icify Yes or No- Rican, etc.)	14. Race - Ameni Black, White,	
5-0036	72 hours 'natural', dical Eva		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ng 1	6b. Kind of Business/In	dustry
12121	filed within Hygiene. other than ent, the Me	Completed	Elementary/Secondary (0-12) 12 th College (1-4or 5+) Washer 17. Father's Name (First, Middle, Last) College (1-4or 5+) 18. Mother's Name	1	(a und	/ Warkie
Maryland	d 2 should be f th and Mental P ? Is marked of traumatic ever	To Be	RUFUS LAW SON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	AL Er	by	, Code l
	s 1 and 2 s if Health an Item 27 la i other treui		7 10 0 0 11	on st	BOL + D	21216 own, State
altimore,	t. Pages rtment of rtant: If It		·4 Donation 5 Other (Specify)	1-04 I	Jun dal	RMD
Ba	permi Depa Impo any ir		21. Signature of Funeral Sorvice Licensee 22. Name and Address of Favilty 23a. Part1. Enter the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart fail to. List only one cause on each line.	JV. F N A V.P	BALTO.	M. 21231 Approximate
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Mixed Drug(Heroin and Cocaine) Into:			Interval Between Onset and Death
	Examiner	er	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of):			
'n,	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		<u> </u>	
68760,	tificate be ig physicia as the bur	ledicai				
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
	quires that the signed by all be detacted.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the	10
Division of Vital Records,	The law requir cate has been si page 2 should	Completed		24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 \(\) No 26. Place of Death to the position of the property of the prope) nce 6 X Other (Specif	CODNE
on of	iding Physician: The thr. After this certificate har funeral director, page		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Formal 28b. Time of Work? Work?	28d. Describe how	v injury occurred	/ SCEIVE
Divisi	al or Attandi s after death. I Director: A id in by the fu	Certification:	3 Suicide 4 Homicide 4 Homicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	e City, Md	oth Street
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau	use(s) and manner as si te and place, and due to	ated. the cause(s)
	vithir To th	M	29b. Signature and title of certifier And Hallau MA OCME		o. Date signed (Month, JULY 2, 200	- ,
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Stree	t, Balti	more, Mary	land 21201
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 4 2004			

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			State Registrar				-	rtificate of		_	Reg. No.	106	22156
	Physicia	an	1. Decedent's Name							2. Date of De Month July 9		Year	3. Time of Death
	/Medic	al	Williner Se	bastian M		herl		4h City Town	or Location of Deat			unty of Death	8:00 P M
	Examin	er		is Hospice	e street and num	001)			- Dulaney V			Ltimore	
	Funeral		Social Security N	lumber 6. S		. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs	B. Date of Bir	th		place (State or Foreign ntry)
	Director		215 38 884		XM 20F	80	Yrs.	World Cay S	110010 111111	March 28	1924	Baltir	moreCo., MD
	land ow		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Many a-fsh ified	tor	Maryland	Baltimore		Bal	timore (County					1 ☐ Yes 2 ☐ No X
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28a-f show event, I'm Medical Examinar must be notified at	Funeral Director	10e. Street and Nur					10f. Zip Code			-	of What Cou	ntry?
	eath w	eral	4565 Ridge	Koad	12. Was Deced	lent Ever in II	18 13	21236	Hispanic Origin? /	Specify Ves or No	USA 14	Race - Ameri	can Indian
' 0	fter de	Fun	 Marital Status Never Marri 	ied 2 Married	Armed Ford 1 X Yes 2 If Yes, Give	ces?	1		Hispanic Origin? (S can, Mexican, Puer	to Rican, etc.)	14.	Black, White,	
PM 0036	rel', o	þ	3 🗌 Widowed	4 ₹ Divorced	If Yes, Give Year or Dat	tes: WW I	I	1□Yes 2□ x No	Specify:		Sp	ecity: Wh	ite
5-0	"natu	letec	(Ѕрес	15. Decedent's E cify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Occu kind of work done	ipation e during most of wo ed)	rking	16b. Kind	of Business/In	dustry
8:00	withir ene. then	Completed	Elementary/Seco	ondary (0-12)	College (1	4or 5+)	Mainter		<i>50)</i>		Baltin	mre Cau	nty Maryland
08 1 d 21	other	Be C	17. Father's Name	(First, Middle, Last			1.22.00		18. Mother's Na	me (First, Middle,			icy renyments
Vlar	Menta Menta arked atic e	To E	Anthony G							M Dieter			
07/09/04 08:00 PM Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinst must be notified at once.		19a. Informant's Na Florence G		Type, Print)				t and Number or R		-		Code)
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<u> </u>	Depar Depar Impo eny ir		LOH	har oss	edn Ch	anac	74	401 Belair	eral Home I Road Balti	more, Maryl	and 212	236	
			shock, or hea	ırt failure. List only	plications that ca one cause on ea	used the deat ch line.	th. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause disease or condition resulting in death)	(Final on				Lon Cance	r				
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م م	that the od by detac	/ Ph	Part II. Other signif		contributing to dea	ath but not res	sulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
ox sp	quires n sign Jid be	d b								1 🗆 '	Yes 2□N	lo 3 ☐ Prot	pably XXUnknown
Mohr of Vital Records,	S S	plete								24a. Was		4b. Were auto	ppsy findings available mpletion of cause of
Ä	sician: The law certificate has b irector, page 2 s	Com								perfo	rmed? 2∭No	death?	·
Mohr of Vita	Physician: this certific ral director,	Be	25. Was case refer examiner?		Hospital:			0		ath (Check only o			
of o	Phys r this sral dis	To L	1 ☐ Yes 2X		28a. Date of	finjury	ER/Outpatier 28b. Time o	f 28c. Inju	4 □ Nursing i	dome 5 Resident		_) Hospice
ion	Attending r death. ector: After by the fune	atlor	1 X Naturał 2 ☐ Accident	5 Pending investigation		n, Day Year)	Injury		ork? ∃Yes 2⊟No				
Wilmer Division	or Atte	Certification:	3 Suicide 4 Homicide	6 Could not to determined	200. Flace	of Injury - At h g, etc. (Speci		eet, factory, office		28f. Location (S City or Tox		um <i>ber</i> o <i>r Rur</i> a	al Route Number,
30	urs aff		On Continu	1□ Cadifulas B	busisian. To the t			L	dete en dele				
	Hospitel 24 hours a Funerel I etely filled	Medical	29a. Certifier (Check only one)			sis of examina			time, date and plac opinion, death occ				
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and	title of certifier)				ise number		29d. Date s	igned (Month,	Day, Year)
	14			de de la constante de la const	/-			DI	13725		07/	12/04	
	1211		30. Name and addi					·		n Marian	and a second	PWINNEG	
	Sta	ate.	31. Date filed (Mon		32. Re	300 Du] egistrar's Signa			ad, Timo	nium, MD	2109	93	
	Registr			JL 1 4 201		neva	A.S.	Sports					

			For State Registrar	, ,,,,,,	State of Ma	ryland			nt of Hotel		Mental	Hygien	2001	221	67
<u>}</u>	Physicia /Medic Examin	an al	1. Decedent's Name A + E y 4a. Facility Name (If	nn Ma	street and number)			4b. City	, Town, gr	Location of De	- Jon	142	ay Year	12 No	o M
	Funeral Director		Anne 5. Social Security Nu NIA	1	110	Cen (In yrs. la	st birthday) Yrs.	If Under	r 1 Year	If Under 24 Hi Hours Mi	rs. 8. Date n. (Mor	of Birth	9. Bi	Armderthplace (State or Man	
	Rangiand	Director	Usual Residence of 10a. State Mayland	Anne A	trindel	10c. City,	Town or Lo	lor.				10.6		10d. Inside Cin	
	ath with the 23a or 2		10e. Street and Num	wicks					211			V		states	
2-0036	within 72 hours after death with the Maryland ene. then "neturel", or Itams 23e or 28es's show the Medical Exercit et must be notified at	i by Funeral	11. Marital Status 1 (23)Never Marrid 3 Widowed	ed 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 Yes		spanic Origin? n, Mexican, Pue Specify:	(Specify Yes	tc.)	14. Race - Am Black, Wh Specify:		
21215-0	d within 72 hagiene. In the Medical	Completed	(Speci	15. Decedent's Edify only highest gra		+)	16a. Deced (Give life. L	kind of w	ual Occupa ork done d use retired)	uring most of w	vorking	16b.	Kind of Busines	s/Industry	
Maryland	should be filed nd Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)	eon Mc	Cla	in			18. Mother's N	th len		4 1	enry	
	1 and 2 sho Health and I tem 27 is me		19a. Informant's Na Arthory 20a. Method of Dist	McClan	1 Forther	20b. Pla	1135 ace of Dispo	sition (Na	one of	ford C		fton	or Town, State,	21114	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ances.		1 Burial 2 4 Donation	5 Other (Specify		0	etro 210 22 H	Cre	mat	ory 7 sof Pacility French	-9-0	4 Bo		ore n	
	Physician /Medical		23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List only Final	dications that caused one cause on each lin	e. Ext	trem		•	n, such as card	iac or respira	tory arrest,	POUS	Approximate Interval Betwoonset and D	een
3760,	te be executed ysician and be burial-transit	Ical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nmediate ortying injury	b. Due to (or as a c. Due to (or as a d.	conseque	ence of):								
.O. Box 68	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 1 9 □ Unknown	months?	23c. If yes, outcome of the control	2 Fetal	death 3□	Ectopic Other (s	pregna <i>nc</i> y specify)				23d. Date of d Month		ear
Δ.	uires that the de signed by the a id be detached t	by	Part II. Other signif	icant conditions	ontributing to death bu	it not resul	lting in the u	nderlying	cause give	on in Part I.	236	Did tobacco	~ -	to the cause of de	
Il Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed										. Was an autopsy performed?	prior to death?		vailable use of
f Vital	ding Physician: Th n. Affer this certificate funeral director, pag	To Be	25. Was case refer examiner?		Hospital: 1 Phopaties	nt 2 🗆 E	ER/Outpatier	nt 3 🗆 🗈	Othe Othe	26. Place of D			6 □Other (Sp	ecify)	
ion of	ding n. After fune		27. Manner of Deat 1 Natural 2 ☐ Accident	5 Pending investigation		Year)	28b. Time of Injury	f M	28c. Injury Work 1 🔲 Y	at ?? ∕es 2 □ No	28d. Des	scribe how in	ury occurred		
Division	in Direct	Certification:	3 Suicide 4 Homicide	6 Could not b determined	e 28e. Place of Injubulding, etc	ry - At hor :. (Specify)	me, farm, str)	eet, facto	ery, office			ation (Street or Town, Sta		Rural Route Numb	oer,
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	29a. Certifier (Check only one)		nysician: To the best of niner: On the basis of and magner sta	examinati									
	To th within To th	Me	29b. Signature and	title of certifier	1119 +	>			9c. License				ate signed (Mo		
	\		30. Name and addr	ress of person who	completed cause of de tanson Co	eath (Item	23a) (Type,	Print)	Debo	9708	tehurs	4-BM	oun	7	
Ē.	Sta Regist	ate rar	31. Date filed (Mon	NOFTH oth, Day, Year) 1111 1 4 2	32. Registra	ar's Signat	ure L	re \$1.	14),	BOWIE	, 1110	injian	a 20	14/	

Physiciai Medica/		1. Decedent's Name (First, Middle,	Last) No 1 c	son Loui	Certificate of Section 1981.	Sr.		2. Date of De			3. Time of Death
		NELSON L	- HENGE	+ Hour	o nenger,			July	06 Day	Z OOK	18.45 1
Examine		4a. Facility Name (If not institution,	1.	001	0.01	vn, or Location				County of Deat	
uneral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birth	nday) If Under 1 Y		er 24 Hrs.	8. Date of Bi	th	Otmor 9. Birt	hplace (State of Foreign
irector		215-34-2322	1√∑M 2□F	67 Y	rs. Months Da	ays Hours	Min.	05/26	$\frac{1}{2}$		nsylvania
A =	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			•			10d. Inside City Limit
a-f sh iffied s	jo	Maryland Harfo	ord	Havr	re de Grad	ce					1 ☐ Yes 2 📉 N
or 28 be no	Director	10e. Street and Number	3		10f. Zip Coo	078			10g. Citiz	zen of What Co USA	ountry?
ns 23e	Funeral	312 Lockhart (12. Was Decedent B	ever in U.S.	13. Was Decedent If Yes, specify (Origin? (Sp	ecify Yes or No)- 1	14. Race - Ame	nican Indian,
. 9	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? to Yes 2 □ N If Yes, Give Year or Dates:	io	If Yes, specify (Rican, etc.)		Black, White Specify: W	_{e, etc.} hite
"netural",	eted	15. Decedent' (Specify only highest	s Education grade completed)	16a. I	Decedent's Usual Od (Give kind of work do life. DO NOT use re	ccupation lone during m	ost of work	king	16b. Kir	nd of Business/	Industry
than Te Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	apervisor			INCILL	Enc	gineeri	ng
vent,	BeC	17. Father's Name (First, Middle, L						e (First, Middle			
varked vetice	0	Charles Henry Me		101				rtha De			
27 Is n r treun	1	19a. Informant's Name/Relationsh Wanda S. Mengel,			Mailing Address (St. 12 Lockhai						
Department of regalls and wester hygiene. Important: If Item 27 Is marked other than "netural any Injury or other treumetic event, the Modical Ex- once.	1	20a. Method of Disposition 1 ☑Barial 2 ☐ Cremation	3 Removal from State	cemetery	Disposition (Name of crematory or other	r place)		Date		cation - City or	
tant: I		4 Dogration 5 □ Other (\$6	ecity)	Bel Air	Mem. Gai		7–10			Air, M	D
eny In	Į	2 Signature Company of the L	icense	-	McComas	funeral	al Ho	me, P.A		MD 21	000
	-	3a. Part I. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do no	1317 Color of enter the mode of	Kesbur f dying, such	y ROd as cardiac	or respiratory a	rrest,	, 1317 21	Approximate Interval Between
sician ledical aminer		Immediate Cause (Final disease or condition resulting in death)	4. 1	le injur	ies with			1			Onset and Death 36 days
	_			a consequence o	f):						1000
	9	Sequentially list conditions, if any, leading to immediate	b. Due to (or as t	a consequence o							30 011/3
transit	amine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as t	B eurisaquerios d	th:				wite a		30 011/2
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ORIGINAL

Physician /Medical Examiner VIDLET M. MILES Sinci Hospital of Bultimore Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) Sinci Hospital of Bultimore Ab. City, Town, or Location of Death N/A	Time of Death I 100 A ^M (State or Foreign
[Medical Examiner] 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Bultwore 5. Social Security Number 5. Social Security Number 5. Social Security Number 7. Age (In yrs. last birthday) 1. March 19 Security Number 1. March 25 Security Number 9. Birthplace (Months) Day, Year) 9. Birthplace (Country) 9. Birthplace (Country) 1. March 25 Security Number 1. March 25 Security Number 1. March 26 Security Number 1. March 26 Security Number 2. Social Security Number 3. Social Security Number 4. Country of Death N/A (Months) Days Hours Min. (Month, Day, Year) 9. Birthplace (Country)	(State or Foreign
Sinai Hospital of Bultimore Bultimore N/A Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 9. Birthplace Country)	(State or Foreign
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace Country)	(State or Foreign
	MD
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location 10d. In Manifold 10d. In MD 10b. County 10d. Street and Number 10d. Street and Number 10d. Street and Number 10d. Street and Number 10d. Street and Number 11d. Marital Status	nside City Limits I∰XYes 2⊟No
Top. Citizen of What Country?	
E 1203 WILDWOOD PARKWAY 21229 USA	
The state of the s	ndian,
Specify: BLAC Specify Specify Specify: Specify	K
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. Do NOT use retired) 16c. Value of Work done during most of working life. Do NOT use retired) 16c. Kind of Business/Industry (Give kind of work done during most of working life. Do NOT use retired) 16c. CASE WORKER	у
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANNIE E. SAVDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Codd UICHELE, V. FASLEY	61 21702
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21. Signature of Funeral Service Licensee 22. Name and Address of Facility VALIGHN C. GREENE FUNERAL SERVICES 5151 BALTIMORE NATIONAL PIKE BALTO MI	21270
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, 1)	,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	04
JENNIFER E. COLES MD Sinai Hosp. of Baltimore 2901 W. Be	Wedere
State Registrar State Registrar RES - 000 July 11 20 RES - 000 July 11 20 RES - 000 July 11 20 RES - 000 July 11 20 RES - 000 Ave., Bait. N	10 ZIZI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stete Registra AMEND ITEM #18 PER FH G833 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year ELEANOR MIDDLETON 6:50 PM 07 /Medical 05 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 212 VALLEY BROOK DRIVE SILVER SPRING 7. Age (In yrs. last birthday)

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F 220-18-6994 VA Yrs. Director 09 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23e or 28a-f shov treumatic event, the Modical Examinating that the nutified at MD MONTGOMERY SILVER SPRING Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 VALLEY BROOK DRIVE 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify: Specify: BLACK 3 ₩idowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) 12th grade TEACHER PUBLIC SCHOOLS Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be f Health and Mental I HILDA WHITE HILDA ONLEY JOHN HANDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Pagas 1 and 2 ment of Health a ent: If item 27 is ury or other tre GWENDOLYN WHITING 212 VALLEY BROOK DRIVE SIWER SPRING MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. GARRISON FOREST 07/15/04 DWINES MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUCHN C. GREENE FUNERAL SERVICES 5151 BALTIMORE NATIONAL PIKE BALTIMORE MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** norwia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death cartificate be axecuted burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. the à Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. OVasai 1 Tyes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on Other: Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 sidence 6 Other (Specify) Manner of Jeath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Discribe how injury occurred 28b. Time of After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: / fillad in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29a. Certifier Medical (Check only one) or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

b

1 4 2004

31. Date filed (Month, Day, Year)

29b Signatur

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print)

			1 - For State Registrar	State o	of Marylan		artment rtificate				lental Hy	giene	004	221	71
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	Examin	ner	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice	4b. City, Town, or Location of Death Baltimore County	4c. County of Death Baltimore
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4	withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			20 None and address of a second place of a second s	1243125	
87	-1		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. Tariq Mahmood 2300 Dulaney	Print) Valley Road, Timonium, M	D 21093
	Sta		31 Date filed (Month Day Year) 32 Registrar's Signature		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 1426 July 10, <u>Felix James Norris</u> 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1₫M 2□F 215-28-3783 Yrs 72 **Director** Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Hillside Drive 21015 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 X Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korean 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (James Edgar Norris Nellie A. Jaworsky 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Norris / Wife 1514 Hillside Drive, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Grdns. 7-14-04 4 □ Donation 5 □ Other (Specify) Bel Air, Maryland 21. Signature | Func | Service Lion see ^{22 Name and Address of Facility} McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 fat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complications, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) smonanna Non Physician /Medical **Examiner** Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Norris, Felix Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 Inpatient Certification: To 3∏ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours after To the Funeral Dire the Hospital 1 🗜 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. July 12th, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MIN (M.D.) GOZ South Attorond Road # 200, Bei Air, MD 21014

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

1 4 2004

32. Registrar's Signature Betwee & Sparts

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Timothy D. Pickens, Jr 8 /Medical 2004 4:00 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 727 Druid Park Lake Drive Balto N/A 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min 10XM 2□F Hours Director 260-64-7891 2-29-1944 Ga Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show traumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Md Director N/A Balto 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 727 Druid Park Lake Drive 21217 SA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married ☐Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Maryland permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster 12th grade 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy Pickens, Sr Inez Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Pickens - Wife 727 Druid Park Lake Drive Balto, Md 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Oglethorpe Crematory 7-19-2004 Brunswick. 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Avenue Balto, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) De ste Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ves 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: Be director, 25. Was case referred to medical 26. Place of Death | Check only one examiner's Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 - No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funers ... To the Funerel Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horull 4000 31. Date filed (Month, Day, Year) 732. Registrar's Signature JUL 1 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** POTTER 2004 KIMBERLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A If Under 24 Hrs. If Under 1 Months 8. Date of Birth (Month, Day, Y 9/2/1957 9. Birthplace (Stete or Foreign 5. Social Security Number 6. Sex 7. Age (Intyrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F MARYLAND 46 Director 213-68-3653 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once. 28a-f show 1 ☐ Yes 2 No NOTTINGHAM BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 10 PICKENS COURT Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BANK OF AMERICA BANK TELLER 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACQUELINE HUTSON HARRY C. BIRKMAIER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8705 LITTLEWOOD ROAD BALTIMORE, MD HARRY C. BIRKMAIER FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 7/17/2004 CATONSVILLE, MD 5 Other (Specify) ³ 4 □ Donation 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signatury of Funeral Service Licensee TOWSON, MD 8521 LOCH RAVEN BLVD. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL HEMORRHAGE **Physician** disease or condition resulting in death) /Medical Examiner COAGULOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit AMYLOIDOSIS that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 No o 9 Unknown 9 Unknown page 2 should be detact ď 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, FAILURE KIDNEY FAILUR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an VERSUS HOST DISEAS autopsy 1 Yes 2 □ No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 3 🗌 Suicide 6 □ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY ENSTROM 600 HORTH WOLFE STREET BALTIMORE, MD 21287 32. Registrar's Signature State JUL 1 4 2004 Registrar

		•	For State Registrar	State of	Marylan		artment of rtificate o		and Mental Hy	/giene Reg. No	ΩL	22176
			1. Decedent's Name (First, Middle	, Last)					2. Date of D	eath/ Pay	Year,	3. Time of Death
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	Examin		4a. Facility Name (If not institution	, give street and numi	ber)		4b. City, Town	n, or Location o	f Death	4c. Count	ty of Death	,
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	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2/CX F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Day		Min. (Month, D	av, Year)	Count	
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	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
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	the r 28a	Director	10e. Street and Number			, , , , , , , , , , , , , , , , , , , ,	10f. Zip Code	ө		10g. Citizen of	What Count	ry?
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ă	ed at at	To Be	John Halley					Kat	ie Zemba			
Maryland	2 should be and Mentat Is marked raumatic ev	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stre		r or Rural Route Numi	ber, City or Town	n, State, Zip	Code)
	日本25世		Elmer J. Halle	y, Jr. (Ne	ephew)	1193	E. Mah	ogany 1	Lane, Crown	nsville,	MD 2	1032
<u>o</u>	es 1 ar of Hea of Hea fitem r othe		20a. Method of Disposition WBurial 2 Cremation	2		Place of Dispo cemetery, crer	sition (Name of matory or other)	place)	Date	20c. Location	- City or Tov	wn, State
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a	permit. Pag Department Important: any injury o		21. Signature of Funeral Service	#Icansee		22	Name and Ad Hardest	dress of Facility	ral Home, 1	P.A.		
n	827 29		777- 4.6	7-			12 Ridg	ely Ave	enue, Annap	polis, M	-	
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	/Medical Examiner		rosaling in assist,	Due to (o	r as a cons	uence of):						
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39	leath certifica attending ph I for use as th	Physiclan/Med	IF FEMALE:	I V	66.							
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Division of	or Ati fter d Sirect in by	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 289. Place	of Injury - At h g, etc. <i>(Speci</i> i		reet, factory, offi	ice		(Street and Nurr own, State)	iber or Hural	Houte Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Me	29b. Signature and title of certific	1. 11	+	11 5	29c. Lic	ense number	(02	29d. Date sign	ed (Month, E	Day, Year)
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	15		30. Name and address of person	who completed cause	of death (Iter	m 23a) (Type,	Printh / 1/ A	Conto	326, SiLVE	o con.	I al	0 22001
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	Sta Registi		31. Date filed (Month, Day, Year	nna Zen	y said s Signi	6	April.					

			1 - For Stete Registrar	State of Maryla		artmen rtificat			and M	F	Rag. No	AL 22177
	Physici /Medio		Decedent's Name (First, Middle, Last) JOEL			PETA	SKY			2. Date of Dea Month JULY	Day 9,	Year 2004 10:45 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c. Count	
ı			3209 SMITH AVENU	E				BALT		RE		BALTIMORE
	Funeral		5. Social Security Number 6. Second Second Security Number 6. Second Second Second Security Number 6. Second Sec	7. Age (In y	rs. last birthday)	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 0CT • 9	Year)	Birthplace (State or Foreign Country)
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	Mary Fish	ţ	MD BALTI	MORE	BALT	IMORE						1 ☐ Yes 2 1 No
	r 28e	Director	10e. Street and Number			10f. Zip					10g. Citizen of	What Country?
	23e c	a D	3209 SMITH AVENUE					2120	8(U.S.A.
	ems er	Funeral		 Was Decedent Ever in Aπρed Forces? 	n U.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spo	ecify Yes or No- Rican, etc.)	14. Rac	ce - American Indian, ick, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		1 ☐ Yes		Specify:		,,	Specif	
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Maryland 21215-0036	ges 1 and 2 should be filed within 7: It of Health and Mental Hygiene If Item 27 Is marked other then "n. or other treumetic event, It a M. All	. 1	19a. Informant's Name/Relationship (Ty									, State, Zip Code)
	1 and Health em 27 ther t		MYRA PETASKY / W 20a. Method of Disposition		3209 b. Place of Dispo			ENUE		LTIMORE		
Baltimore,	Pages nent of Heart o		1 ☐ Burial 2 X Cremation 3 ☐ F	emoval from State	cemetery, cre	matory or o	ther place					- City or Town, State
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Ba	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		A SthVI La	H/V2.					SUL			ROS., INC. LLE, MD 21208
THE PERSON NAMED IN	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	CHRONIC RE	eath. Do not en	ter the mod						Approximate Interval Between Onset and Death
8760,	ficate be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause Extra Uncertainty Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons								
.O. Box 6	the death cert by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of predictions of the second of the s	etal death 3	Ectopic pro						ate of delivery onth Day Year
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00	> 0 0	ompleted	COPD							24a. Was a		Were autopsy findings available
Re	0 4 B	E O								autops perform	med?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place	of Death	Check onl on		103 2010
Ž <	S S S	Tof	examiner? 1 ☐ Yes 2 🏋 No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 □ DO	A Othe	r: 4□ Nur	rsing Hor	me 5 X Reside	ence 6 Oth	ner (Specify)
ion of	ding h. After fune		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	f 2	8c. Injury Work 1 □ Y	at ? ′es 2 □ N		28d. Describe ho	ow injury occur	red
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	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my lar: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	h occurred avestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, d	ause(s) and ma ate and place,	anner as stated. and due to the cause(s)
	To the within 2. To the I	Σ	29b. Signature and title of certifier	la No		29c	. License	number		2	9d. Date signe	d (Month, Day, Year)
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	1.0		30. Name and ddress of person who co DEBORAH MORRIS, M		tem 23a) K CENTE		#20	0	OWI	NGS MIL	LS, MD	21117
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature							

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			For State	State of Maryl		ertificate of			. N@ () [22170
36.	YE?	#	Registrar 1. Decedent's Name (First, Middle, Last)			erinicate or	Death	2. Date of Death	. Ng.	3. Time of Death
(04"	Physicia		ELEANIOR	PORTI	NEY			Month 12	May Year	335A M
	/Medic Examin		4e. Fecility Name (If not institution, give s		4-7	4b. City, Town, o	r Location of Death	199	4c. County of Dea	ath
			NORTHWEST HOSPITA	L CENTER		RANDALI			BALTIMOR	
3	Funeral		5. Social Security Number 6. Sex 1215-24-8118		yrs. last birthd 71 Yrs	Months Davs	Hours Min.	8. Date of Birth (Month, Day, Y JAN. 12, 1	9. Bi	rthplece (State or Foreign Country)
•	Director		Usuel Residence of Decedent	^	/1			UAN. 12,1	933	שכ
	yland		10a. State 10b. County	100	. City, Town o	r Location				10d. Inside City Limits
	e Ma	Director	MD BALTI	MORE	RE I	STERSTOWN				1 🗆 Yes 2 🗖 No
	with th		10e. Street and Number	T.V.E		10f. Zip Code	01106	10g	. Citizen of What C	
	172 hours after death with the Maryland "natural", or Itema 23a or 28a-f ehow calcal Examitrational be notified at	Funeral	12351 BONCREST DR	IVE 12. Was Decedent Ever	in U.S.	13. Was Decedent of H	21136	pecify Yes or No-	14. Race - Am	U.S.A.
0	r Item	Fun	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 🕅 No		13. Was Decedent of H If Yes, specify Cub		Rican, etc.)	Black, Wh	ite, etc.
ğ	within 72 hours after ene. than "natural", or Ite	1 by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
2-0	natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(0	ecedent's Usual Occup live kind of work done	during most of work	king 16	b. Kind of Business	s/Industry
121	within Bne. than	duic	Elementary/Secondary (0-12)	2 College (1-4or 5+)		'e. <i>DO NOT use retire</i> EMAKER	a)	01	WN HOME	
2 2	be filed within 72 ho ital Hygiene. id other than "natur event, Itia Moucal	Be Cc	17. Father's Name (First, Middle, Last)		110111		18. Mother's Nam	e (First, Middle, Ma		
lan	2 should be filed and Mental Hygi ie marked other aumatic event,	To B	HARRY	BELKOWITZ			BETTY			GABE
Maryland 21215-0036			19a. Informant's Name/Relationship (Ty	· ·		ailing Address (Street			*	
	1 and 1ealth om 27 ther tr		LARRY PORTNEY / S 20a, Method of Disposition			B51 BONCRES			C. Location - City o	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		1 X Burial 2 ☐ Cremation 3 ☐ P	emoval from State	cemetery, IBERTY	sposition (Name of crematory or other place PARK SHAAF		3/2004		STOWN, MD
	permit. P Departme Importan any injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		IDENTI	22. Name and Addre				
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	82 F.		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the	death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	END STAG	E Con	GESTIVE	HEART	FAILUI	RE.	Onset and Death
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		e e	Sequentially list conditions,	Due to (or as a cor	nsayuunce :f):					
	d d ansit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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876	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: Atter this certificate has been signed by the attending physician and ector: Atter this certificate bas been signed by the tuneral director, page 2 should be detached for use as the burial-transit.	dicai		J						
Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Medl	IF FEMALE:	3c. If yes, outcome of pr	egnancy				23d. Date of de	playen
8	atten affor u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		Month	Day Year
o.	by the	hys	9 Unknown	9□ Unknown						
S, F	signed I	by P	Part II. Other significant conditions con	ntributing to death but no	t resulting in th	e underlying cause gr	ven in Part I.			to the cause of death?
ord	w requir been si should							1 U Yes	2 No 3 F	Probably 4 Unknown
ec	has b	Completed						24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
a	n: The licate r, pag		25 111					1 □ Yes 2		
Ĭ	s certification	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	2 ☐ ER/Outpa	atient 3 DOA Oth	200	th <i>(Check only one)</i> ome 5 Residence	e 6 □Other /So	acity)
٥	ig Phy ter this	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Tim	e of 28c. Injur	man a	28d. Describe how		00.197
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Division of Vital Records, P.O.	after d Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm pecify)	, street, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely tilled in by the funeral director, page		29a. Certifier 1 X Certifying Phy	sician: To the best of my	y knowledge, d	leath occurred at the til	me, date and place	, and due to the caus	se(s) and manner a	as stated.
	n 24 h	edical	(Check only 2 Medical Exami one)	ner: On the basis of exa and manner stated.	mination and/o	or investigation, in my o	opinion, death occur	rred at the time, date	and place, and du	e to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	12-m 9	am.0	29c. Licens			Date signed (Mon	
7	\) January	1 III ONE	4 11110	L)	14140		uly 1214	/
	1		30. Name and address of person who co		A	rpe, Print) Jo	MINDER	P MEY	ATA	2
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Gents Gignature	EK KAK	10 Hills 1	DMH W	0 411.3	3 *
	Regist		JUL 1 4 2004 A	renewey &	1 20	als				

			_ For	State of Maryland	/ Departm	ent of H	ealth and M		3	
			1 - State Registrar		Certific	cate of L	Death		Reg. No. () () ()	22179
	Physici /Medio Examir	cal	4a. Facility Name (If not institution, give	NEY RICE	4b.	City, Town, or	Location of Death	2. Date of Dea Month	Day Year	4 5:00PM
			UNIV. OF MARYLA				MORE		NA	
	Funeral Director		5. Social Security Number 6. Security 1217-69-0214	7. Age (In yrs. las	Yrs. 2	nder 1 Year iths Days 7	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day APR 30,	9. Bi 2004 MAR	rthplace (State or Foreign ountry) YLAND
	yland		10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
	e Mar	ctor	MARYLAND NA	BAI	TIMORE					1 XYes 2 No
	vith th	Director	10e. Street and Number		101	f. Zip Code			10g. Citizen of What C	ountry?
	ns 23g	Funerai	418 POPLAR GROVE S	STREET 12. Was Decedent Ever in U.S.	13 Was D	21223	enanic Origin? (So	cifu Vas or No-	USA 14. Race - Am	erican Indian
036	72 hours after death with the Maryland natural; or items 23a or 28a-f show deat Examinate must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		specify Cubar	spanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	Specify: AF	RICAN ERICAN
Maryland 21215-0036	d within 72 ho plene, r than "natur ine Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. DO NO	of work done d OT use retired)	uring most of work	ing	16b. Kind of Business	s/Industry
22			17. Father's Name (First, Middle, Last)	NA	NEVER	WORKEI		/First Middle	NA Maiden Sumame)	
ylanı	e d is p	To Be	TIMOTHY C. EVANS				NICOLE		maiden Samame)	
	12 s h ar 7 is trau		19a. Informant's Name/Relationship (Tyr. VIVIAN C. BANKS (pe, Print) GRANDMOTHER					r, City or Town, State, MORE, MARY	
ore,	r it		20a. Method of Disposition 1		ce of Disposition netery, crematory	(Name of or other place	,)	Pate	20c. Location - City or	Town, State
Ĕ	Pages ment of lant: If it		'4 Donation 5 Other (Specify)		ZION CE	METERY	JUL 1		LANSDOWNE	
Baltimore,	permit, Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	2	22. Nam	N . GTI	of Facility WYL	IE FUNE	RAL HOME P E, MARYLANI	.A.
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):			10011	1-11	
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	cuted nd ransit	Examiner	triat initiated events							
760,	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a conseque	nce of);					
_	physic physic the b	dicai		i.						
Box (death certificat e attending phy d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnanc					23d. Date of de	livery
Ď.	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de 4 Pregnant at time of deal 9 Unknown		r (specify)			Month	Day Year
<u>о</u> .	that the de ted by the a detached i		9 ☐ Unknown Part II. Dther significant conditions cor		na in the underhi	20 201100 2110	n in Doct I	220 Did to	hanne was centribute t	the course of death?
Vital Records,	sign sign d be	ed by	- arring strong significant contactions con	minuting to death but not result	rig in the underlyi	ng cause give	mmrani.		bacco use contribute t es 2□No 3□P	robably 4 Unknown
eco	e law requ has been je 2 shoul	Completed						24a. Was a		utopsy findings available completion of cause of
		Con						perfori	med? death?	2 □ No
Z Z	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Othe	26. Place of Death			
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=	in the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	ctory, office	2	28f. Location (St City or Town	treet and Number or R. n, State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occur n and/or investiga	rred at the time tion, in my opi	e, date and place, a nion, death occurre	and due to the ca	ause(s) and manner as ate and place, and due	s stated. s to the cause(s)
	Fo the within of the comple	Me	29b. Signature and title of certifier			29c. License			9d. Date signed (Mont	
,	N		> Asthana	- m		117	765		Tuly (0,2004
	7		30. Name and address of person who co	mpleted cause of death (Item 2:	3a) (Type, Print)	094,	72 S G	REENE	STI MA	TMORE 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur					1-1-1-1	

DHMH 17 Rev 1/2001

JUL 1 4 2004

ORIGINAL

Physician Medical Examinor As Petalis Name If not instruction, give steer and number) As City, Town, or Location of Death As County of Death			State Registrar 1. Decedent's Name (First, Middle, La	ist)		Cei	rtificate d	or Dea	ain	2. Date of De	Reg. No.	UO	2219
## Facilities Variance Teacher Secretary Association Secretary Sec		-		•							Day		
Social Section Number Section			4a. Facility Name (If not institution, given	e street and number)	<u>-</u>	4b. City, Tow	n, or Loca	tion of Death	July	7		
The first of the control of the cont				ad							Mont	gome	ry
To. Since In Montgomery Takoma Park To. Since and Number MD Montgomery Takoma Park To. Since and Number 6802 Red Top Road To			579-58-3607							(Month, Da	v, Year)		country)
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11. Mother's Name (First, Modes, Last) 12. Mother's Name (First, Modes, Makes Summers) 13.	ours after of ten	by Fur	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔀 If Yes, Give	No		_			lican, etc.)		Black, Wh	ite, etc.
The salter same (First, Middle, Asien) Simples Str.	"natur	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Oc kind of work do	cupation ne during	most of workir	g	16b. Kind o	f Business	s/Industry
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23a. Part 1. Enter the disease, or complications with caused find plants. Do not enter the mode of dying, such as cardiac or respiratory arrest, indevelopment shock, or heart failure. List only one cause on each line. 25a. Part 1. Enter the disease, or complications with caused find plants and the property of the pr	uld by	TO B	Christopher C. S	Snipes, Sr				F	annie A	. Flor	ence		
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Immediate Cause (Final disease or conditions continued in the past 12 months?) Due to (or as a consequence of): Due to (or as a consequence	= 20		23a. Part1. Enter the disease, or com	plications that cause	d the dea	th. Do not ent	er the mode of o	tying, suc	h as cardiac or	respiratory ar	rest,	שלו פּו	Approximate
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PALLE TO THE TAXABLE PALLET TO THE TAXABLE PALLET TO THE P	")	_	30. Name and address of person who	completed cause of	death (Item	n 23a) (Type, I			,		-	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien,e Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mont Year 1130 PM 10 ZOOY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDAUSTOW H Under 1 Year | If Under 24 Hrs. BALTIMORE NORTHWEST CENTER HOSPITAL MO Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 1 F -46-5040 Director Yrs. Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 ✓ Yes 2 No Director 10e. Street and Number 10g, Citizen of What Country? 2211 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Marital Status in U.S 14. Race - American Indian, traumatic event. The Medical Examiner Black, White, etc. 1 Never Married 2 Married 2VINO 1 ☐ Yes ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) chool Teacher 18. Mother's Name (First, Middle, Maiden Sumame is markad of if item 27 other 20a. Memod of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other 0 Department Important: If any injury or once. ^¹ 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility town 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, be 1 🗌 Yes 200 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 🗌 Yes 2 No 1 ☐ Yes Division of Vital director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tes 21XER Outpatient Certification: To 1 🔲 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) funeral Manner of Dath 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 0 the Hospital within 24 hours a Certifying Physicien: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) Medicel Exeminer: On the basis of examination and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ,200 (0 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Da

4 2004

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Signature

32. Registrar's

Box 68760,
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Records,
Vital
ivision of

		1 - For State Registrar	State of Man		Certificate of		-	Reg. No.	1000	2218
Physic /Medi		Decedent's Name (First, Middle, Carl Harry	Shunk, Jr.				2. Date of De Month	Day		3. Time of Deal
Exami		4a. Facility Name (If not institution,		_	4b. City, Town, o	r Location of Death		4c.	County of Death	
		FRANKLIN SQU				EDALE If Under 24 Hrs.			BALTIM	
Funeral Director		5. Social Security Number 214-34-3729 Usual Residence of Decedent	10XM 2015	n yrs. last birth	Months Days	Hours Min.	8. Date of Bir (Month, Da March	th iy, Year) 26 ,	9. Birthp Cour 1936 Mary	lace (State or For ntry) /Land
faryland show		10a. State 10b. County	10	Oc. City, Town	or Location				1	0d. Inside City Lin
e Mar	ctor	Maryland Harfor	rd	Edgewo	od					1 ☐ Yes 2√∑
within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Madical Examiner must be routified at	al Director	10e. Street and Number 614 Red Oak Aver.	nue		10f. Zip Code 21040			10g. Citi	izen of What Cour A	ntry?
ems ser mu	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No	-	14. Race - Americ Black, White,	
s after	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☑ No If Yes, Give 2		1 ☐ Yes 2 ☐ No	Specity:	7 110411, 010.7		Specify:	etc.
d 2 should be filed within 72 hours af the and Mental Hygiens 17 is marked other then "natural", or traumatic event, the Medical Exami	ed b	15. Decedent'	Year or Dates:	16a. [Decedent's Usual Occup	ation		16h Ki	ind of Business/Inc	nite
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should I	၉	Carl Harry	Shunk, Sr			Marcella		izab		Pearce
12 sh h and 7 is m traum	1	19a. Informant's Name/Relationsh			Mailing Address (Street					
an		Vergie M. Shunk 20a. Method of Disposition		20b. Place of I	Red Oak Av		gewood, Date		YIANG 21 cation - City or To	
permit. Pages 1 ar Department of Hea Important: If item 3 any injury or other ODCE.		1 ☐ Buriat 2 ☐ Cremation 1 ☐ Dolation 5 ☐ Other (Sp	3 □Removal from State	-	, crematory or other place		/04			
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permit. Departi Importi any inj	1	1/4/4	ar 11/		1317 Cokes					
		23a Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the	e death. Do no	ot enter the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
Physician	١,	Immediate Cause (Final disease or condition	NFECT	MIS	COLITIS	,				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of						
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	sic	1 Yes 2 No	4☐ Pregnant at tim 9☐ Unknown	e of death	5 Other (specify)				WOTH	Day Year
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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

ANA

31. Date filed (Month, Day, Year)

Cura E

JUL 1 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD

82. Registrar's Signature

29c. License number

O.C.M.E.

29o. Date signed (Month, Day, Year)

July 06, 2004

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gertrude J 2004 Wehr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rose BALTIMORE dale If Under 24 Hrs. HOSPILA MARE 8. Date of Birth
(Month, Day, Year)
December 28 1918 Rossville, Maryland 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Min. 1 □ M 2 🖵 F Hours 85 212 03 6841 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County or than "natural", or items 23s or 28s-f show the Medical Examinat must be notified at Maryland Baltimore Baltimore County Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 USA 7712 Queen Anne Drive Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify Specify: 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than ' Irry or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Amanda Wilhelmina Schuster Ret. Col. John Asbury Hughes Jr ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Juanita L. Gaston (Daughter) 2503 Wentworth Road Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State July 14 2004 Baltimore, Maryland Baltimore National Cem. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Tassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 marcac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acule MI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 24a. Was an page 2

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who comp death (Item 23a) (Type, Print) DR. BAITIMORE Md 9000 FRANKLIN Novello DR NONA 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

Year

2153

10d. Inside City Limits

Approximate Interval Between Onset and Death

White

1 Yes 2 No

State Registrar

DHMH 17 Rev 1/200

certificate

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After

24 hours after death. 9 Funeral Director: A

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Certification:

Medical

Division of Vital Hospital or Attending Physician:

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	/Medi		Doris Creswell							July		2004		30 AM [™]
	Examir	ner	4a. Facility Name (If not institution, give	•				Location of	f Death		4	c. County of De		
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	Funeral Director		-		73 Yrs.	Months		Hours	Min.	8. Date of E (Month, I	Day, Yea.		Sirthpiace (Country) aryla	State or Foreign nd
	nyland how		10a. State 10b. County	100	. City, Town or Lo	cation							10d. In	side City Limits
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	or 24	Dire	10e. Street and Number			10f. Zip	Code				10g. C	itizen of What	Country?	
	s 23s	a	1453 Landis Circl		ے ۔		1015					USA		
	ltam Itam	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever i	n U.S. 13.	Was Deced If Yes, spec	lent of His cify Cubar	spanic Orig n, Mexican,	in? (Spec	cify Yes or N Rican, etc.)	lo-	14. Race - Ar Black, W	nerican Inc hite, etc.	lian,
336	irs af	by F	3 Widowed 4 □ Divorced	1 ☐ Yes 2 █ Y No If Yes, Give Year or Dates:		1 ☐ Yes 2	2 No	Specify:				Specify:	rate d	t
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	To the Hospital within 24 hours a To the Funeral completely lilled	edical (29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred a estigation,	t the time	o, date and p nion, death	place, an occurred	d due to the at the time,	cause(s date and) and manner a d place, and du	s stated. e to the car	use(s)
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			ALFIRD SI	32, Registrar's Sig	tem 23a) (Type, P	PHAI	1 1	MA	12	11/3	21	014		
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	Physici /Medic		Decedent's Name (First, Middle, Last Margaret Houston		Y				2. Date of De	Day Yea	3: Time of Death 1255 PM
	Examin		4a. Fecility Name (If not institution, give				4b. City, Tov	vn, or Location of Dea	ath]	4c. County of D	
			LORIEN @ R 3	VERSIDE	-	last birthday)	BEL,	CAMP ear If Under 24 Hi			Birthplace (State or Foreign Country)
	Funeral Director			□M 2 ⊠ F	87		Months D	ays Hours Mi	Dec. 2		ssachusetts
	yland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
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to	uth with the Maryland 23a or 28a-f show ust be rotified at	ral Dire	10e. Street and Number 601 Philadelphia	Road				21085		10g. Citizen of What USA	
byr	within 72 hours after death with the Marylan ene. then "naturel", or Items 23a or 28a-f show to Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No		Was Decedent If Yes, specify 1 ☐ Yes 2X	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specity Yes or No erto Rican, etc.)	14. Race - A Black, W Specify:	nencan Indian, hite, etc. White
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Mand	ed ala	To Be	Philip Henry Hou	ston				Maude	(MMN) Br	runel	
→ Mary	2 sh and ls m	(time	19a. Informant's Name/Relationship (er, City or Town, State A, MD 21085	
je Ž			20a. Method of Disposition			Place of Dispo cemetery, crei	osition (Name o	of r place)	Date	20c. Location - City	or Town, State
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_	(8		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type,	Print)	and rd	Bel	An Ansi	0/4
the	St Regist	ate rar	31. Date filed (Month, Day, Yeer)		trar's Sign	g de	souls				

			For	State of Ma		epartment of		Mental Hy	giene		
			1 - State Ragistrar			Certificate o	f Death		Reg. No. ())4	22187
	Physic		1. Decedent's Name (First, Middle, Las	Watson	Src.			2. Date of Dea Month	Day	Year	3. Time of Death
	Exami		4a. Facility Name (Il not institution, give BALTINURE VAI)		Center	4b. City, Town	or Location of Dea		4c. Count		
	Funeral		5. Social Security Number 6. Se		(In yrs. last birth	day) If Under 1 Year Months Day	ar If Under 24 Hr		h	9. Birthp	lace (State or Foreign
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	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. In side City Limits
	Man a-f sh iffed	tor	MARYLAND BALTIMO	RE	PIKI	ESVILLE					1 ☐ Yes 2134No
	or 28a-f	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	s 23a	rail	8200 DARIEN CT.			212			U.S.	Α.	
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Baltimore,	permit. Pages 1 a Department of Hee Important: If item any injury or otha once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other pi	lace)	Date	20c. Location -	City or To	wn, State
Ħ	permit. Pages Department of Important: If it any injury or c		 4 □ Donation 5 □ Other (Specify) 21. Signature of Furneral Service License 		CROWNS	VILLE VETE					, MARYLAND
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	e Hos 124 ho e Fun letely	dicai	(Check only 2 Medical Exami	sician: To the best o ner: On the basis of and manner stat	examination and/o	r investigation, in my	opinion, death occu	e, and due to the ca arred at the time, da	iuse(s) and mai ite and place, a	nner as sta nd due to f	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed	(Month, D	ay, Year)
7			12/2/19		117	13-	11497	6	57/10,	104	
	2t'		30. Name and address of person who co		ath (Item 23a) (Ty	oe, Print)	Clari.	56 16	2011	0	0 2/20/
	Sta	e	David (Sarangno A 31. Date filed (Month, Day, Year)	1D 32. Registra	's Signature 🦽	יוטן	ME ENE C	theet D	NCTIMUM	ca, M	2/201
	- Registr		JUL 1 4 2004	Born	J. Sol	ules					

			1- For State of Maryland		artment of Hortificate of L			iene	22100
	Physici		1. Decedent's Name (First, Middle, Last) AUPREY		WARRE	EN	2. Date of Deat Month		
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		2001	4c. County of Dea	
	LAdilli	ici	NORTH WEST HOSPITAL			ALL STOC	SUL	BALTI	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
	Director		220-20-3260 10M 2XF 74	Yrs.			2-28	-30	MD
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mary -I sho	ţo	mp 1	Bal	+:. 00	0			1 Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What C	Country?
	15 with with 230 c	Funeral Director	2705 West wood AYE		212	17		91. SA	
	ems erms	Iner	11 Marital Status 12 Was Decedent Ever in II.	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 20 No	Specify:	,	Specify: Q	1
8	n 72 hours after death with the Maryland "naturel", or Items 23e or 28a-f show adical Exteriment be notitled at		3 Widowed 4 Divorced Year or Dates:	16a Dece	dent's Usual Occupa	tion		16b. Kind of Business	lack
21215-0036	n "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done di DO NOT use retired)	uring most of worki	ng	TOD. TAITO OF DUSINESS	undostry
217	filed within Hygiene. ther then "	E O	Lief N		Posta			Priva	te Co.
		Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	faiden Surname)	
Maryland		၉	Leonard Carroll			Audi		Tabror	1
Mar	0 m m	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin				City or Town, State,	Zip Code)
	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. P	lace of Dispo	30 H	/	ack	212 20c. Location - City of	Town State
lo I	0 = =		Burial 2 Cremation 3 Permoval from State		matory or other place	"		,	urnie.MD
Baltimore,	permit. Pag Department Importent: I any injury o	1	21. Signature of Funeral Service License	2 dar	Name and Address	s of Facility		GIGN D	urn.e.mv
ñ	permit. Departi Import any inj		Willey Chank	1	Name and Address Les ley Cho Don East	EVEL AV	+ # e Bal	to 212	31
			23a. Part1. Enter the sease, or complication, that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arre		Approximate Interval Between
2	Priysician	0	Immediate Cause (Final disease or condition		ANCER				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequ						
	Laminer	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ	ionco of)-					
	nsit	nin	cause. Enter Underlying Cause (Disease or injury	ierice ory.					
Ć,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequ	ence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		d						
9	ntifica ng ph as th	Med	IF FEMALE:						
Вох	eath certific attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0.	at the der by the a tached f	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of de 9 ☐ Unknown 9 ☐ Unknown	ath 5	Other (specify)			Telestar.	ody (od)
Q	that the ed by detac		Part II. Dther significant conditions contributing to death but not resu	ulting in the u	nderlying cause giver	n in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
Records,	luires n sign lid be	d by					1 ☐ Ye	s 2□No 3 ⊡	robably 4 Unknown
00	w requir s been si should	Completed					24a. Was an	24b. Were a	utopsy findings available
Be	The lavate has	шо					autopsy perform 1 Yes 2	prior to	completion of cause of
Vital	ilen: T	Be C	25. Was case referred to medical examiner?			26. Place of Death			2010
of V	Physicien: this certific ral director,	2	Hospital:	ER/Outpatier		4 Nursing Hor	ne 5 🗆 Resider	nce 6 Other (Spe	ecify)
n		iuo i	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?		28d. Describe how	w injury occurred	
Division	at sat	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At ho	mo form et		es 2 No	28f Location (Str	eet and Number or R	ural Pouto Number
Di∨	after death Director:	Certification;	4 Homicide determined 286. Place of Injury - At no building, etc. (Specify		eet, factory, office		City or Town,	State)	urai noute Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my know	wledge, deat	h occurred at the time	e, date and place, a	and due to the car	use(s) and manner as	s stated.
	he Ho in 24 he Fu pletei	edical	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my opi	inion, death occurre	ed at the time, da	te and place, and due	e to the cause(s)
	To t To t	Σ	29b. Signature and tifle of extitified		29c. License		29	d. Date signed (Mont	th, Dey, Year)
7			M.	ρ.	DS.	7722	~	JULY 7	2004
			30. Name and address of person who completed cause of death (Item			0	HAAL STO	n. 1414 A	2 112 2
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture _		COAD, KA	NUALLY10	INN M.D.	41155
	Registr			food	<i>i</i>				
		_		at .					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 4 2. Date of Death Day Month Year **Physician** 1600 ·WOOdruA 2004 4b. City, Town, or Location of Death /Medical 4c. County of Death **Examiner** MARITAN If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 2-25.79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M/No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 end 2 should be filed within Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Technician 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ¶ □ Donation 5 □ Other (Specify) Service Licenses 21. Signature of Funeral Approximate Interval Between Onset and Death 23a. Part1. Enter the grease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Myocardia Examiner Completed by Physician/Medical Examiner Athrosclerotic been signed by the attending physician and should be deteched for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 □ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Uncontrolled Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Sepsis secondary to Arteriovenous fistula 1 ☐ Yes 2 X No 1 TYUS 2KNU intection or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? Medical Certification: 5 Pending investigation 1 Natural efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0059290

29d. Date signed (Month, Day, Year)

July 1, 2004

Rock, Raven Blvd. Baltimore, Maryland 2123

State Registrar

29a. Certifier

29b. Signature and title of certifier

Good Samaritan

31. Date filed (Mp) th, Day, Yea 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hosostal

5601

32 Registrer's Signature

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #8 PER FH G834 8/06/19/call of Death Reg. N6) 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Glen. Verlin 2004 Ausmus 12, 10:30AM July /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Year) 1X M 2 □ F Director Sept. 557-16-9323 1919 Colorado Usual Residence of Decedent <u>na</u> death with the Maryland 10b. County 10c. City, Town or Location 10a State Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Nadical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Veirs Drive 20850 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "netural", or itel Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŒXNo Specify: 37 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Uranium Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Love Ausmus Etta Belle Ellison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Dapartment of Health and Important: If Itam 27 Is rr any injury or other traum once. 18657 Tarrajon Way Germantown, Maryland 20874 Carol Heater/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2XX cremation 3 Removal from State July 14, W. Arundel Crematory Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Bevely & Haxitte MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prosician Lerebro Vascular Accident unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Fibrillatio unknown trial Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☑ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? 1 Yes 2 X NO Yes 2 🗆 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 2 uly 12,2004 restinuarlen House Mp 00059871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cristin Parker Howe mo agoi medical center Drive Rodeville, maryland

State

31. Date filed (Month, Day, Year) Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year A Jay Anglin July 11 ,2004 7:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deeth 6640 Prestwick Drive Highland Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□F Months 59 Director 310-48-7841 Apr.29,1945 Indiana Usual Residence of Deceden with the Maryland 10a, State 10b. County Show 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Mayleal Examinar must be notified at 1 Yes X No Directo Howard Highland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6640 Prestwick Drive 20777 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð If Yes, Give --Year or Dates: Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Regional Sales Manager Cardinal Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: if item 27 is marked ott Arthur Earl Anglin Lillian Igo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6640 Prestwick Drive, Highland, Md. 20777
ce of Disposition (Name of Date 20c. Location - City or Town, State Linda L. Anglin/wife 20b. Place of Disposition (Name of cometery, crematory or other place 20a. Method of Disposition Columbia Memorial 7/15/2004 Clarksville, Md 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ ortant: i 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 21. Signature of Funeral Service Licensee permit.
Departn
Imports
any nju lello 5555 Twin Knolls Rd, Columbia, Md.21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Kneumonia **Physician** /Medical Due to (or as a consequence of) Examiner Fronths /e tostatic Cholanis Carcinsma Sequentially list conditions, I any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2/2 No 1 Yes I or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 59032 Me L 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 401 May Brodung Balture, Mariland Johns Horkers Hospital Nose Yair Ley 1ha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2004 Registrar souls

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2 0 0 4 **Physician** Month JULY MURIEL V. ARMSTEAD 8 8р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9-8-1925 Birthplace (State or Foreign Country) **Funeral** 5 1 M 2 □XF Days Hours Director 219-10-944 78 MARYLAND Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23e or 28a-f show polical Examiner must be notified at N/A MD. BALTIMORE Director 1 X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene. 3325 GARRISON AVE. 21215 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK traumatic avant, the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) -12--0-TECHNICIAN JOHNS HOPKINS 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 permit. Pages 1 and 2 s Department of Health ar Important: if itam 27 is any injury or other trau EARL WAKE (SON) 1806 SPANISH OAK LANE MITCHELLVILLE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1∭ Burial 2 D Cremation 3 Removal from State * 4 ☐ Donation 5 Other (Specify) GARRISON FOREST 7-14-2004 OWINGS MILLS, MD. al Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. short, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Periph Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funaral Director: After this certificate has been signed by the attending physician and lated in by the tuneral director. that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the µnderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Vygertensim 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No perform 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEKELMAN MO GBMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July **Physician** 03^{3} 2004 Dorothy Virginia Battley 4:40 A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Montgomery Woodside Center Nursing Home Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign County) | Oct. 18, 1928 | Washington D.C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F Yrs. 75 226-86-8287 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturaf", or items 23a or 28a-f show any njury or other traumatic event, its Moules Examination of the rectilised at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 9101 Second Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be John Battley Elizabeth Harper ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Battley/nephew 4361 Lorcom Lane Arlington, Virginia 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Ju1 Tate 13. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Arundel Crematory 2004 Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-License Going Home Cremation Service P.O. Box 784 ne severy L Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Cerebrovascular Accident Immediate /Medical Due to (or as a consequence of): Examiner Generalized Athrosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2. No 3 Probably 4 Unknown Sepsis, Urinary Tract Infection 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performed? Yes 2X No certificate 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To this After this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director:. completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 GALLANT FOX LY STEDD BOWIE, MD 20715 AKESH ARORA M.D 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JUL 1 5 2004 Registrar Arrents.

1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give Score) 4a. Facility Name (If not institution, give Score) 4a. Facility Name (If not institution, give Score) 4a. Facility Name (If not institution, give Score) 5. Social Security Number 6. Second Score) 45. Second Score) 46. Second Score) 47. Decedent's Edu (Specify only highest grade Score) 48. Core (First, Middle, Last) 48. Core (First, Middle, Last)	street and number) X T. Age (In yrs 10c. C Ba Ave Apt 305 12. Was Decedent Ever in In Armed Forces? 1	S. last birthday) S Yrs. City, Town or Local timol U.S. 13. V	If Under 1 Year Months Days cation re 10f. Zip Code 21	Hours Mir	8. Date of Birth (Month, Day)	4c. County of	S. Birthplace (State or Fo Country) S.C. 10d. Inside City Li
5. Social Security Number 3. 3. 6. Sec. 1 Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 1700 Edmondson 11. Marital Status 1 Never Married 2 Married 3. Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th grade	T. Age (In yrs 10c. C) AVE APT 305 12. Was Decedent Ever in In Yes, Give Year or Dates: cation a completed)	is. last birthday) Styrs. City, Town or Local timos U.S. 13. V	cation re 10f. Zip Code	If Under 24 Hr Hours Mir	s. a. Date of Birth (Month, Day)	28	SC 10d. Inside City Li 1XIYes 2
10a. State 10b. County MD NA 10e. Street and Number 1700 Edmondson 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th grade	Ave Apt 305 12. Was Decedent Ever in It Armed Forces? 1 □ Yes 2♥ No If Yes, Give Year or Dates: cation e completed)	altimon	re 10f. Zip Code 21			20	10d. Inside City Li 1 X 1Yes 2 [
10e. Street and Number 1700 Edmondson 11. Marital Status 1	Ave Apt 305 12. Was Decedent Ever in It Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: cation e completed)	5 U.S. 13. V	10f. Zip Code 21		1	0g. Citizen of Wha	
(Specify only highest grade Elementary/Secondary (0-12) 8th grade	e completed)	100	I□Yes ***No	Specify:	Specify Yes or No- rto Rican, etc.)	Black, Specify:	A. A. American Indian, White, etc.
	College (1-4or 5+)	(Give I life. D	lent's Usual Occup kind of work done DO NOT use retire	during most of wo	me (First, Middle, I		ness/Industry
Andrew DuBose Si	rpe, Print)			Lucill and Number or R	e James	, City or Town, Sta	
20a. Method of Disposition	20b. Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other pla	сө)	Date	20c. Location - Cit	ry or Town, State
21. Signuture of Funeral Service Licens	March	²² Maa 4.3	Name and Address Arch F/ 300 Wab	ash Ave	. Balti	more. M	
snock, or hear failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):		1 1			Approximate Interval Betwee Onset and Deat
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 [Mo	1 ☐ Live birth 2 ☐ Fet	al death 3 □		у		23d. Date of Month	f delivery Day Year
Part II. Other significant conditions cor	tributing to death but not re	sulting in the und	derlying cause giv	en in Part I.			
25. Was case referred to medical			-		autopsy perform 1 Yes 2	prior deat	e autopsy findings avail r to completion of cause h? Yes 2 □ No
examiner? 1	lospital: 1 Tempatient 2 C 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing F y at k?	lome 5 ☐ Reside	nce 6 Other (Specify)
4 Homicide determined	building, etc. (Speci	ify)	,	me date and plan-	City or Town,	State)	,
(Check only one) 2D Medical Examir 29b. Signature and title of cartifier	ner: On the basis of my manner: On the basis of examination and manner stated.	ation and/or inve	29c. Licens	e number	irred at the time, da	te and place, and	due to the cause(s)
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Andrew DuBose Ji 20a. Method of Disposition **ABurial 2 Cremation 3 R **4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart aliure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Pinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Pinal disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Tho 9 Unknown Part II. Other significant conditions condits conditions conditions conditions conditions conditions conditi	Andrew Dubose JrBrother 20a. Method of Disposition **Meurial 2	Andrew DuBose Jr.—Brother 20a. Method of Disposition X. Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Sign title of Funeral Service Licensee 22a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 23b. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. 25c. Immediate Cause (Final disease or condition resulting in death) 25c. Due to (or as a consequence of): 26c. Due to (or as a consequence of): 27c. Interpolation 2 Pert of the part	Andrew DuBose Jr.—Brother 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory or other plate) X In Jonation 5 Other (Specify) 21. Signification of Funeral Service Licenese 22a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dylishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or conditions) Tally is conditions, and addition of the plate of	Andrew DuBose JrBrother 20a. Method of Disposition X-Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee King Memorial Park 7/ 22a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock or heart failure. List only one cause on each line. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock or heart failure. List only one cause on each line. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock or heart failure. List only one cause on each line. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock or heart failure. List only one cause on each line. 23a. Parti. Enter the mode of dying, such as cardial shock or heart failure. List only one cause on each line. 23b. Was decedent pregnant in the past 12 months. 25 List only one cause or injury and in the past 12 months. 25 List one contributing to death but not resulting in the underlying cause given in Part I. 25 Was case referred to medical examiner? 26 Parti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25 Was case referred to medical examiner? 26 Parti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 27 Manner Death 28 Date of Injury 28 Date of Injury at home, Iarm, street, factory, office building, etc. (Specify) 28 Date of my knowledge, death occurred at the time, date and place (Check or partition) 29 Date of or the basis of examination and/or investigation, in my opinion, death occurred at the line, date and place (Check or partition) 29 Date of or the basis of examination and/or investigation, in my opinion, death occurred at the line, date and place of partition. 29	Andrew DuBose JrBrother 1322 Ingleside Ave, Balt X Burial 2 Cremation 3 Removal from State X Burial 2 Cremation 3 Removal from State 4 Donalis 5 Dither (Specify) 21 Signature of Fueral Service Licenage King Memorial Park 7/19/04 22 Annean and Address of Facility Andren and Andren and Address of Facility Andren and Andren and Address of Facility Andren andren and Address of Facility Andren andren and Address of Facility Andren andren and Address of Facility Andren a	Andrew DuBose JrBrother 1322 Ingleside Ave, Baltimore, Weburs 2 Chemator of Disposition (Name of commentary canal place) and the control of Disposition (Name of commentary canal place) and the control of Disposition (Name of commentary canal place) and the control of Date 200. 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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day HELEN E. BAKER JULY 14, 2004 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7990 PHIRNE RD. E GLEN BURNIE ANNE ARUNDEL 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MARCH 30,1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NEW YORK **Funeral** 1 □ M 2 → F 75 124-22-8185 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7990 PHIRNE RD. 21061 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "ne any niury or other treumetic event, the Medic 2005: Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, LOUIS LAUN ELSIE JONES 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT J. BAKER / HUSBAND 7990 PHIRNE RD., E, GLEN BURNIE, MD 21061 20a. Methon of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State JULY 15, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY, INC. ' 4 ☐ Donation (5 ☐ Other (Specify) 2004 CATONSVILLE, MARYLAND 22. Name and Address of Facility
KIRKLEY-RUDDICK
421 CRAIN HWY., S.E., GLEN BURNIE; MD 21061 of Funding Service Lic se 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician a ACUTE CARDING ARRHYTHMIA disease or condition resulting in death) ACU TE /Medical Due to (or as a consequence of): **Examiner** IN FARCTION ACUTE MYULARDIA Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): **LONG STANDIA** Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by PRIOR M YOCARDIA IN FARCTION 3 Probably 4 □Unknown 1 🗌 Yes んぽドケ ientric ulma DYS FUNCTION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has autopsy After this certificate har funeral director, page perform 2 No 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thingful ws d-10-0030834 JULY 15, 2004 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) 6 STAFFORD 22 S. GREENE ST., BALTIMORE, MD 21201 JAMES 4. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State boards Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Physician Year Roland W. Blockinger, Sr. 11, July 12:45cm /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of MD Medical Center Baltimore City N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y 10/05/1937 **Funeral** 5 Social Security Number 217–34-4295 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 1**25**€M 2□ F **Director** Yrs. Maryland Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location Items 23e or 28e-f shov 10d. Inside City Limits MD N/A Baltimore City Completed by Funeral Director MYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2660 Frederick Avenue 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iten any injury or other freumetic event, the Modical Examinar once. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo 3 Widowed Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) **7th** College (1-4or 5+) Maintance Port Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles W. Blockinger, Thomasina 2 Metzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland W. Blockinger, Jr. / Son 2660 Frederick Avenue, Baltimore Maryland 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Bay View Crematory July 15, 2004 Baltimore Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jaska Janton En disease or condition resulting in death) raumatic /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 Other (specify) detached 9 Unknown 9 Unknown þ certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 **V**Mo 3 Probably 4 □Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2D No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident
3 Suicide
4 Homicide 2 04 1 Yes 2 No I Director: / menoun -all on steps 6 Could not be 28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 73 Sargeant St, Bytmore, MD To the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pel

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		tificate of De	aith and Mental I <i>eath</i>	Hygiene Reg. No. 0	4 22197
	Physic	ian	1. Decedent's Name (First, Middle, La-				2. Date of Month	Death	3. Time of Death
	/Medi		Albert J.				July	13, 200	
7	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Lo		4c. County o	f Death
			Joseph Richey Ho 5. Social Security Number 6. S		la a thirdh da . N	Baltime If Under 1 Year		N/	
	Funeral Director			<u> </u>	. last birthday) 35 Yrs.		f Under 24 Hrs. 8. Date of (Month, Sept.	Birth Day, Year) 22,1918	9. Birthplace (State or Foreign Country) North Carolina
	land ow		10a, State 10b. County	10c. C	ity, Town or Lo	cation			10d. Inside City Limits
	Man Hed	to	Maryland Howard	E1]	icott	City			1 ☐ Yes 2 ☑ No
	th the	irec	10e. Street and Number			10f. Zip Code		10g. Citizen of Wh	21
	th wil	aiD	3106 The Cascades	Court		2104	2	USA	
	r dea	Iner	11. Marital Status	12. Was Decedent Ever in I	J.S. 13. \	Vas Decedent of Hispa	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	No- 14. Race	American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exemper must be motified at 2008.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 📆 Divorced	Myes 2 No 41 Myes, Give Year or Dates: 45	-		Specify:		White, etc. Black
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occupation	on ing most of working	16b. Kind of Busi	iness/Industry
121	vithin ne. han a	I du	Elementary/Secondary (0-12)	College (1-4or 5+)	1 -	kind of work done duri OO NOT use retired)	ing most of Working		0
	iled v Hygie ther t		12 17. Father's Name (First, Middle, Last)		Photo	ographer			Government
Maryland	d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the Me	Be				18	I. Mother's Name (First, Mid		
Z	should Me mark mark	2	George Bullock 19a. Informant's Name/Relationship (7)		10h Mailin	a Address (Street and	Miranda Bail Number or Rural Route Nur		
<u>@</u>	and 2 salth ar		Daisy Richardson				es Court Elli		
ē,	s 1 and f Health Item 27 other tr		20a. Method of Disposition	20b.		sition (Name of patory or other place)	Date	20c. Location - Ci	
Ę	Pages nent of I int: If It		1 ☐ Burial ② ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Homoval Hom State		ratory or other place) rematory In	nc. 07/14/04		
Baltimore,	permit. Pag Department Important: I any injury o	H	21. Signature of Euneral Service Licen					Baltimor	e, MD
<u> </u>	89789		Thomas Gregor			emation So 99 Frederic	of Facility Ociety Of Mar ck Road Balti	yland Inc. More Mary	land 21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea	th. Do not ente	er the mode of dying, s	uch as cardiac or respiratory	arrest,	
	Physician		Immediate Cause (Final disease or condition	CVA					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due (or as a consec	quence of):				111
		<u></u>	Sequentially list conditions,	b. Tylut	non	~			glas
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or us a consec	(uence or):				
—	execunand nand ial-tra	Examine	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):				_
68760,	tificate be executed ig physicien and as the burial-transit			d.					
	rtificat ng phy as th	Medical							
Вох	eath cert attendin for use	an/N	Loo. 1144 Goodanit pragnant	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy		23d. Date of	of delivery
-	The law requires that the death certificate be executed tte has been signed by the attending physicien and rage 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o		Other (specify)		Month	Day Year
P.0	that the		Part II. Other significant conditions po		udia a ia Maria	4-4-3	- D - U		
Records,	signe bed t	i by	2010 Page 10	nuibuting to death but not res	uiting in the un	derlying cause given in			ite to the cause of death?
Ö	w requir been si should	etec	ILT XX AA	i .					☐ Probably 4 ☐Unknown
3ec	has las	Completed	- NIDDIV				24a. Wa	topsy prio	re autopsy findings available r to completion of cause of
<u>a</u>								rformed? dea	Yes 2□No
Vital	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner?	Hospital:		Other	. Place of Death (Check only		chen Hospica
of		\vdash	1 Yes 2 Alo	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injury at	Nursing Home 5 ☐ Re	sidence 6 Other (Specify)
lon	Attending F r death. sctor: After by the funera	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work?	2 No	e now injury occurred	**
Division	Attern des	Hice	3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, stre		28f. Location	(Street and Number of	or Rural Route Number,
۵	tel or	Certification;	4 Homode	building, etc. (Specif	y)		City or T	own, State)	
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edicai	29a. Certifier 1 Certifying Phy (Check only one) 1 Medicel Exemi	sicien: To the best of my kno ner: On the basis of examina	wledge, death tion and/or inve	occurred at the time, destigation, in my opinio	late and place, and due to the in, death occurred at the time	e cause(s) and manne e, date and place, and	er as stated. due to the cause(s)
	o ths ithin o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License nur		29d. Date signed (A	
	⊢ s ⊢ ō		1/10			Din	E77	171.0	1-20-26
	021		30. Name and address of person who co	ompl ause of death (Iten	1 23a) (Tvne P	rint)	-0 /-	01113	1000
	871		Dr. Robert Liss 83				. MD 21201	1	1
	Sta Registr	te	31. Date filed (Month, Day, Year)	Registrar's Signa		/ .			

			1 For Stata	State of Maryland			l Mental Hygi	ene	
			Registrer 1. Decedent's Name (First, Middle, Last,)	Cerunc	ate of Death	2. Date of Death	g. No.	3 Time of Death
	Physici /Medi		JOSEPH	F	30GDA	N	Month	Day Year 10 200	(835 P. M.
	Examir		4a. Facility Name (If not institution, give	street and number)		ity, Town, or Location of De	ath	4c. County of Deat	
		7		nedicar cente		DER AR		HARFE	mo
	Funeral Director		5. Social Security Number 6. Set	7. Age (In yrs. Ia	ast birthday) If Un Monti	der 1 Year if Under 24 H ns Days Hours Mi	n. (Month, Day,	Year) 9. Birti	hplace (State or Foreign untry)
			Usual Residence of Decedent	9	0		July 9	1914	WA
	nylan	_	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Be-fe	Director	MD HarFo	ro	Bel	air			1 NYes 2 No
	with th	Dire	10e. Street and Number	111	10f.	Zip Code	10	g. Citizen of What Co	untry?
	death with the Maryland ms 23e or 28e-f ehow f must be notified at	eral	1310 E. Scot	150019 LV	12 Was Da	21015	(O	USA	
S	r iten	Funeral	1 Never Married 21 Married	Armed Forces?	If Vac o	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	Specify Yes of No- erto Rican, etc.)	14. Race - Amer Black, White	ncan Indian, e, etc.
<u>8</u>	within 72 hours after ene. then "naturel", or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1940	1 1 1 YAS	2 No Specify:		Specify:	Mite
5-0	72 h natu dical	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Decedent's U (Give kind of	work done during most of w	orkina 16	6b. Kind of Business/I	ndustry
12	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	use retired)		- \	4
م 2	filed with Hygiene other the		17. Father's Name (First, Middle, Last)	5+	leac		ame (First, Middle, Ma	Educat	ION
<u>la</u>	Mental Mental Arked c	To Be	John Boad	`aV\		Allen	ita K	inc	
Maryland 21215-0036	2 should and Men is marke	_	19a. Informant's Name/Relation (Type		19b. Mailing Addre	ess (Street and Number or I	Rural Route Number,	1 100	ip Code)
	and 2 ealth m 27 i		Kathryn Bogdan	n wife	1310 E.	Scottsdale	Dr. Bebi	y, mb:	21015
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23e or 28e-f ehow with injury or other treumatic event, the Medical Examiner must be notified at ODGe.		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ R		ace of Disposition (finetery, crematory of	lame of r other place)	Date 20	c. Location - City or T	own, State
Ħ	it. Pa rtmen rtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify)	M			1 resear	Balto, r	nD
Ba	permit, Departr Importe any inj		21. Signature of Fineral Service License	VII	22. Name	and Address of Facility	1 11 1		A
34	*		23a. Part Enter the disease, or compli	cations that caused the death.	. Do not enter the m	ode of dving, such as cardia	ac or respiratory arres	. Tresson L	A 18434 Approximate
	Physician	8 (I	Immediate Cause (Final	e cause on each line.	0-12		and the spiratory arros	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	ASYSTAL			10 MIN ,
	Examiner		Sequentially list conditions.	seure c	AZDIDM	you alm			Verus
	ed isit	lue	Sequentially list conditions, if any, loading to inniversal cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	•	1 4	4		
	and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque		ardiovasar	landis.	ense	11 years
68760	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical	d						
68	rtificat ng phy as th	Medi	The second secon						
Вох	eath certifi attending p	by Physician/M	Lob. 1143 decedent pregnant	Bc. If yes, outcome of pregnand 1 Live birth 2 Fetal of	cy death 3⊟Ectopic	pregnancy	JIA	23d. Date of deliv	ery
o.	at the des by the al	/slci	in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	4☐ Pregnant at time of dea 9☐ Unknown				Month	Day Year
<u>.</u>	res that the igned by be detact	Ph	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying	cause given in Part I	23a Did tobar	cco use contribute to t	he serves of death?
Records,	uires n sign		Diahetes		ang ar tho andonying	oduse given in Fait i.			bably 4 Hunknown
Ö	s been si should b	lete					24a. Was an		
Ä	The law cate has page 2:	Completed					autopsy performe	d? prior to co	opsy findings available impletion of cause of
		BeC	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	No 1 ☐ Yes	210 No
o 10	Physic this ce al dire	2	1 ☐ Yes 2 WNo	ospital: 1 Inpatient 2 E	R/Outpatient 3 [Other	dome 5 Residence	e 6 Other (Specif	(y)
n C	ding P h. After t funera	ou:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 2 (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
DIVISION	death death ctor: y the	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	M	1 Yes 2 No	004 1 10 10-		
<u>≥</u>	il or At after o i Direct d in by	Certifications	4 Homicide determined	building, etc. (Specify)	ie, iaim, street, iacto	огу, опісе	City or Town, S	et and Number or Rura State)	al Route Number,
	ospite hours unerel y filler		29a. Certifier 1 Certifying Physi	ician: To the best of my knowl	ledge, death occurre	d at the time, date and place	e, and due to the caus	e(s) and manner as s	tated.
	To the Hospital or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certifics completely filled in by the funeral director,	Medical	(Check only 2 Medicel Examin	er: On the basis of examinatio and manner stated.	n and/or investigation	on, in my opinion, death occ	urred at the time, date	and place, and due to	the cause(s)
	To t Com	Σ	29b. Signature and title of certifier			9c. License number		Date signed (Month,	
	00		- Cayus an	m.D.		D00331	63 1	1/10/2	004
	(2)		30 Name and address o	npleted cause of death (Item 2	23a) (Type, Print)	DOUBBLE N	indica in	1.	Bald à Aus
	Stat	е	31. Date filed (Month, Day, Year)	2. registrar's Signatur	A /	MADJUHLE NO	WUUHE CE	Men .	see mil ind,
164	Registra	ır	JUL 1 3 2004	person to	1 Span	Est			

		,	For State	State of Maryl		artment of h				00100
			State Registrar Decedent's Name (First, Middle, Las	t)	Cel	runcate or	Deaiii	2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medio		Robert G.	Bassett	e			July	10 200	4 0100 M
	Examir	er	4a. Facility Name (If not institution, give	street and number) Manyland Me	dies Couls	4b. City, Town, o	Himor		4c. County of De	ath
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date of Bir		irthplace (State or Foreign Country)
	Director		220-56-4054 1 Usual Residence of Decedent	AM 2UF 49	Yrs.			APR 9	, 1955 Dist	rict of Columbia
	yland		10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Be-1 e	Funeral Director	Maryland Anne Aru	ndel		Harwood			10a Citizen of Miles	1 Tes 2 No
	with th	Dire	10e. Street and Number 4069 Sands Road			10f. Zip Code 20776	5		10g. Citizen of What (country?
	death	nera	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.			gin? (Specify Yes or No , Puerto Rican, etc.)		
36	s after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1	1□Yes 2XNo		•		7hite
21215-0036	within 72 hours atter death with the Maryland ene. then "netural", or Items 23a or 28e-f ehow he Medical Exercities is at be multiked at	ted t	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occu	pation	of working	16b. Kind of Busines	s/Industry
218	vithin 7 ne. hen "n	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use retire	nd)	-	0-16	. 1
	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)	1	Priva	te Mail_I		DUTLON r's Name (First, Middle)	Self-emp , Maiden Sumame)	этоуеа
'lan	2 should be f and Mental h Is marked of reumatic ever	To Be	Philip Bassette				Anni	e Laura Shi	rum	
Maryland	iges 1 and 2 should be filed within 72 hours atter death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then "netural", or items 23a or 28e-1 ehow or other treumatic event. The Practical Extendible 1.	ľ	19a. Informant's Name/Relationship (7					r or Rural Route Numb	•	Zip Code)
	Health Health tem 27		Philip Bassette/E			USCEOLA position (Name of matory or other pla		Titusville,	20c. Location - City of	or Town, State
П	Pages nent of H ant: If ite ury or of		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	detro Cr	ematory or other pla	Inc	7/13/04	Baltimore	e, MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licentum August Au	7~	Š.	remation 99 Freder	Socie	ty of MD, oad Baltimo	Inc.	172
			Fdward A. 1976 23a. Part1. Enter the disease, or companion shock, or heart failure. List only	Corchi k						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Sepsis						Onset and Death
	/Medical Examiner		resulting in death)	Due to or as a cor	nsequence of):					
	DEC.	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cor	nsequence of):					
	acuted ind transit	Examiner	Cause. Enter Underlying Cause (Libeas of hijb) that initiated events resulting in death) Last	c						
760,	sician and burial-transit	Ical Ex	lesoning in death) cast	Due to (or as a cor	isequence or):					
89	A > 0	edic		. d.						
Box	eath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pro	Fetal death 3	⊒Ectopic pregnanc	у		23d. Date of d	elivery Day Year
0.	that the dealed by the a	yslc	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown	of death 5L	Other (specify) _				
Δ.	signed b	by Pi	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	inderlying cause gi	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ord	w require been sig should b									Probably 4 Unknown
Records,	ne law nhas b ge 2 sl	Completed							psy prior to prined? death?	
Vital		0	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only of	2XNo 1□Ye one)	es 2 No
of Vi	Physicien: this certific ral director,	To B	examiner? 1 D Yes 2 XNo		2 ER/Outpatie	III JUDON		rsing Home 5 ☐ Resi		pecify)
ou o	ding P h. After I funera	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Wo	iryat ork?]Yes 2∐1		how injury occurred	
Division	Attending or death, ector: After by the fune	iffica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, st				Street and Number or I wn. State)	Pural Route Number,
Ö	urs after or real Director	Cert								
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:		ysician: To the best of my ninar: On the basis of exa- and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	2			se number		29d. Date signed (Mor	
	Ľ.	1	* thrack to	ratt, MD ((PRATT)	159	185		July Wi	2007
	1.	/		4.4	·	laryland	Med.	tenter 22	S. Greene	87,
	St Regist	ate rar	31. Date filed (Month, Day, Year)	22. Registrar's S	Signature	Court	wie, t			
	J				/ /	/				

			Please	Type or Prin					-	_	le.
			For State	State of Ma	ryland / L	Departmer Certifica				2111	6 22200
			Registrar 1. Decedent's Name (First, Middle, Las	(t)		Cerunca	le UI	Dealii	2. Date of Dea	eg. No.~	3. Time of Death
	Physici	an		7 NN	13	ertor	0011	, ,	Jucy		eer / / = au
	/Medic		4e. Facility Name of not institution, give			- 4b. City	Town, o	r Location of Dea	ith	4c. County of	7
	Examin	er	Esther's	Place A	Livi	Ng 1	BAI	timor	e	,	
	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. last bir	thday) If Under	r 1 Year Days	If Under 24 Hr Hours Mir		Year) S	9. Birthplace (State or Foreign Country)
	Director		213-54-0514	□ M 2 2 5F	91	Yrs.	Days	Tiours	4-8	- 1913	MARY/RND
	pu 🔏		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	laryla aho ed al	5	11			timore					1 Yes 2 No
	28a-1	Director	10e, Street and Number		DAI		D Code			l0g, Citizen of Wh	at Country?
	3a or		1740 - TARK	SON St.	reet		2	1230		K	-5-A
	ms 2	Funeral	11. Marital Status	12. Was Decedent E		13. Was Dece	edent of H	lispanic Origin?	Specify Yes or No- into Rican, etc.)	14. Race -	American Indian,
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0	1 Yes		Specify:	nto rucan, etc.)	Specify:	White, etc.
2-003	eral',	d by	3 ▼Widowed 4 □ Divorced	Year or Dates:							White
2	72 h 'natu	ete	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>	16a.	(Give kind of w	ork done	ation during most of w d)	orking	16b. Kind of Busi	ness/Industry
12	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f ahow ha Madical Exami er mual be notilliad al	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	+)	- 1		AKER		OWN	HOME
2	filed with Hygiene. other ther	ပို	17. Father's Name (First, Middle, Last)			7101	70.0		ame (First, Middle,	Maiden Sumame)	
and	Mental arked c	To Be	Luca	GRA	Nese			Antoin	ette	D	· Nenna
aryl	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (. Mailing Addres		and Number or I	Rural Route Numbe		ate, Zip Code)
≥	and 2 lealth a m 27 le		PATRICIA M.Be	Rtorezzi	- /	740 3	ACH	LSON S	treet E	BAlto. 1	MD 21230
more,	es 1 a of He of He fixem		20a. Method of Disposition 1. Burial 2 Cremation 3	Domoval from State	cemeter	f Disposition (Na ry, crematory or	other place			20c. Location - C	
Ē	Pages ment of l ant: If lts ury or o		'4 □ Donation 5 □ Other (Specify		GARDE	ns of Fa	ith	CEM Ju	y 15, 2004	BALtIA	LORE, MARIA
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	see		22. Name a	and Addre	ss of Facility	UNINO J	e. Fun	CORE, MARINE CRAL HOME MD21224
<u> </u>	20 E 2 9		Charles.	Janne	2	363	Sou	th Col	ukling 5	+. BAlte	MD21224
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	flications that caused one cause on each lin	the death. Do i	not enter the mo	de of dylr	ng, such as cardi	ac or respiratory ari	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. De		ation					Iweek
35	Examiner			Due to (or as a	consequence	of):					
B		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	on.					11
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence	of):					74
921	cate be physicials the bu	cal		d							
(687	The law requires that the death certificate i ate has been signed by the attending physicage 2 should be detached for use as the	Physician/Medic	IF FEMALE:								
Вох	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live birth	2 Fetal death			1		23d. Date Month	
0	the a	/sic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death	5 Other (s	specify) _		-		
<u>α</u>	es that the death igned by the atte be detached for	Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the underlying	cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
Vital Records,	signe d be	d by				, ,			1 🗆 Y	es 2 🗹 No 3	☐ Probably 4 ☐ Unknown
20	v requir been s should	Completed							24a. Was a	10 24h We	ere autopsy findings available
Rec	The lav	du					·		autop: perfor	med2 de	or to completion of cause of ath?
a			25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only or		Yes 22No
	Physiclan: r this certific ral director.	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Ou	utpatient 3 C	Oth	0.00	Home 5 Resid		(Specify)
o	ding Physiclan: h. After this certific funeral director.		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b.	Time of	28c. Injur Wor			ow injury occurred	
Division	Attending r death. ector: After by the fune	Certification:	1. ■ Natural 5 □ Pending 2 □ Accident Investigation	1		М		Yes 2 □ No			
ivis	l or Attendater deatl Director:	tife	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, fa . (Specify)	arm, street, facto	ry, office		28f. Location (S City or Town		or Rural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the								L		
	Hosp 24 hor Fune fely fi	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of niner: On the basis of and manner sta	examination an	e, death occurre nd/or investigation	d at the tir on, in my d	me, date and pla pinion, death oc	ce, and due to the c curred at the time, o	ause(s) and mann late and place, an	ner as stated. d due to the cause(s)
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	F ≯ F 8		> Cleully	141			Ī	151185		July 1	2 2004
11	M		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	-3			July 1	0,0004
	9		Callen Christm				vo Ca	5 Cricle	Baltimor	e mp z	1224
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 817 AM **Physician** Mildred 9+4 2004 Rannerman nly /Medical 4b. City, Town, or Location of eeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Bayview Medical nallimore City Baltimore HOP II Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 1-12-1926 Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 ☐ M 2 🛣 F NC Director 244-20-4814 78 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show If them 27 is marked other than "neturel", or items 23e or 28e-1 sho or other treumstic event, the Madical Examinar must be notted at 1 Yes 2 No DUNDALK MD BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21222 USA APT. 413 101 CENTER PLACE Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentai Hygiene. Important: If Nem 27 Is merked other than "neturel", or flee any Injury or other treumatic event 1 ☐ Yes 2 █****No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: ģ 3 XWidowed 4 ☐ Divorced BLACK Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSING HEALTH 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PEARL MITCHELL JAMES BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3102 SOLLERS POINT ROAD JOHN T. BANNERMAN/SON BALTIMORE, MARYLAND 21222 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-16-04 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 0 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** 6 days /Medical Immediate Cause (Final disease or condition resulting in death) Pneumonia Examiner Due to (or es a consequence ol): Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ate has been signed by the atte page 2 should be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed To the Hospital or Attending Physicien: The law within 24 hours after death.

To the Furneri Director: After this certificate has I completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2. 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 2 □ No 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ohns Hyphins May view Medical Confer HAMMERI 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MARGARET JULY4 2004 8:47 /Medical 4c. County of Death 4b. Cify, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 615 NEW PITTSBURG AVENUE TURNER STATION BALTIMORE 8. Date of Birth (Month, Day, Year) 02-15-1913 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 XF Yrs. 91 Director 219-22-1516 Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Exerciner cost be notified at TURNER STATION 1 X Yes 2 □ No MD BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ŏ 21222 USA 615 NEW PITTSBURG AVENUE 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or Items Black, White, etc. filed withIn 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 2 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STEEL ADMINISTRATION Pages 1 and 2 should be filed a nent of Health and Mental Hygic ant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be BLAND ROSE UNK ARTHUR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 229 CHESTNUT STREET, TURNER STATION, MD 21222 ELVA THORNTON/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State rtment crtant: **ARBUTUS** 7/20/04 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) njury 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC Dep Impol any r ames 9 LAURENS ST., BALTIMORE, MD 21217 1701 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causagiven in Part Je Records. 90 wroma 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an No. 1 ☐ Yes of Vital or Attending Physician: in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 3□ DOA 2 ER/Outpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ביי היי מישי אינור ויי אינוי etely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAUHAR ESSEX 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 1 5 2004

		1. Decedent's Name (First, Middle, Last,)					2. Date of D	eath			3. Time of D
Physici		Steven Mark Br	esnahan					July	10,	2004	Year	0008 A
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I Health and Mental Hyglene. Item 27 is marked other then "naturel", or items 23s or 28a-f show other traumatic event. The Medical Exart are trust be retilised at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎦 Divorced	1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates:		1 ☐ Yes 2 %					Specify:	Whi	
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other other vent.	a	17. Father's Name (First, Middle, Last)				18. Mc	other's Nam	ө (First, Midd				
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and M Is mar aumat	Г	19a. Informant's Name/Relationship (T)	ype, Print)	19b. M	ailing Address (S	Street and Nur	nber or Ru	ral Route Num	ber, City	or Town, St	itate, Zip l	Code)
alth a		Thomas Bresnahan	(Brother)		Memori		T .	-	-			
of Health I Item 27 r other tra		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation 3 🛰 🕉	Removal from State	20b. Place of Di cemetery,			1	Date		Location - C		
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death. tror; Affer this certificate has been signed by the attending physician and inpoping the funeral director, page 2 should be detached for use as the burial-transit and input.	Certification: To Be Completed by Physician/Medical Examin	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown Part II. Other significant conditions cond	a. Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown ontributing to death but Hospital: 1 Inpatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	t 2 XER/Outpar (Specify) The death. Do not on the consequence of the	atient 3 DOA e of ry M street, factory, or leath occurred at or investigation, in	inancy inancy iffy) 26. Pl Other: 1 Yes 2 office the time, date n my opinion,	art I.	23e. Dic 23e. Dic 24a. We autiput 24a. We autiput 28d. Describe 28d. Describe 28d. Describe 28d. Describe 28d. Describe	arrest, t t tobacco Yes as an lopsy formed? 2 \(\text{N} \) y one) sidence e how injuiction own, Sta te cause(e, date ar 29d. D	23d. Date Month ouse contribution as contribution of the principal of the	of deliver the Dute to the Dute to the Dute to the Dute to the Dute to the Dute to compath? If (Specify) deliver or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or Rural or or or or or or or or or or or or or	Approximate Interval Between Onset and De O / S / S / A

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	Physic /Medi		1. Decedent's Name (First, Middle EDITH MAE BA								2. Date of De. Month JULY	ath 11, Day 200	4 Year	3: Time of Death 4: 20p M
3	Exami	4a. Facility Name (If not institution 4509 VALLEYV		-	Town, or LTIM	Location of	of Death			4c. County of Death				
	Funeral Director		5. Social Security Number 213-34-3413	6. Sex 1 ☐ M 2 ∏ F	7. Age (In yrs. 74	Vre	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 4-20-	y, Year)	Cou	place (State or Foreign htry)
	faryland ahow	5	Usual Residence of Decedent 10a. State 10b. County MD • N/	٨		y, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the N a or 28e-1 be notifi	Director	10e. Street and Number 4509 VALLEYV			DALITM	10f. Zip	Code 212	06			10g. Citizen of \		
336	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-1 ahow or other traumatic event, the Marical Ext. That is usable notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed For ied 1 Tyes	2 □XNo		Was Deced f Yes, spec	ent of Hi	spanic Orio	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		e - Americ ck, White,	can Indian, etc.
Maryland 21215-0036	vithin 72 hou ne. han "natura e M. dic	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	lite. L	lent's Usua kind of wor DO NOT us FIGUR	k done d e retired)	luring most)		ng	16b. Kind of Bu	usiness/In	dustry
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	and 2 should lealth and Men m 27 is marke her traumatic		19a. Informant's Name/Relations RHODA WILKES			1:	301 Н	ILLS				r, City or Town,		
altimore,	t. Partmer		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S) 21. Signatur □ 15 □ ral Service	pecify)	State A	lace of Dispo emetery, cren RBUTUS	natory or of MEMO	her place RTAT.	PARK	. 7	ate 16–2004	20c. Location -	ODE	MADVIANO
Ba	Depa Impo any ir	la u) Joseth	O. HUE	mer	1	721 – 2	7 N.	MONR	OE S	T. BALI	UNERAL	HOME MARY	LAND 21217
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. 447	PS//	fee						i Noma	1	Approximate Interval Between Conset and Death
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2	law requires that as been signed b 2 should be deta	leted by Pl										cco use contribute to the cause of death?		
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_	ing Phys ifter this ineral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date o (Month		ER/Outpatient 28b. Time of Injury		Other	4 🗆 Nur	sing Hom	(Check only on e 5 Preside 3d. Describe ho)
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	학생 등 등	Medical	one) Medical	g Physicien: To he la examiner: On the baland manni	sis of examinat	vledge, death ion and/or inv	estigation,	in my opi	nion, death	place, ar occurred	d at the time, d	ate and place, a	nd due to	the cause(s)
	vith To Con	4	29b. Signal and dittle st certifier	TIMO	0 1	/is/u	4 D	30	14 C	7	2	9d. Dale signe	(Month, I	Day, Year)
سن	6		30. Nam and address of person of the state o	who completed cause Drive	of death (Item)	nM	D H	200	7	He	ctor	51/00	2, KI	nD.
	Sta Registr		JUL 1 5 20		week	19	door	EN						

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			For State	State of Maryland		ificate of		ind Men		2001	20205
			Registrar 1. Decedent's Name (First, Middle, Last)		Oerti	incate of	Death	2.1	Reg.	NO. U U IS	3. Time of Death
	Physici	an	Gloria	J. Brady					Month July 1:	Day Year 1 2004	300 AM
5	/Medic		4a. Fecility Name (If not institution, give s			4b. City, Town,	or Location of		, 41) 1.	4c. County of Dea	th
	Examin	ier					1timo			N /	
	Euporal		300 W. 28th Str 5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 2		Date of Birth Month, Day, Ye		hplace (State or Foreign
	Funeral Director		220-68-4818	M 201 6	1 Yrs.	Months Days	Hours	Min. A T	or 10.1	1943 I	llinois
	<u> </u>		Usual Residence of Decedent	140.00.3	-						,
	unylar show	_	10a. State 10b. County		Town or Loca						10d. Inside City Limits 12☐Wes 2 ☐ No
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	vith th	<u>-</u>	10e. Street and Number			10f. Zip Code	1211		10g.	Citizen of What Co	
	be filed within 72 hours after death with the Maryland Ital Hygiene. id other than "natural", or Items 23a or 28a-f show event, the Medical Examinal must be nutified at	by Funeral Director	300 W. 28th Str	12. Was Decedent Ever in U.S.	13 W:			nin? (Specify	Yes or No-	14. Race - Ame	
	Item Item	Į,	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 Yes 2 No	F	as Decedent of res, specify Cut		Puerto Rica	in, etc.)	Black, Whit	
336	urs af	by	3 Widowed 4 Divorced	If Yes, Give TY Year or Dates:	10	⊇Yes 2Å No	Specify:			Specify:	white
9	2 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decede	nt's Usual Occu	ipation	of working	16b	. Kind of Business	Industry
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Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type							ty or Town, State, 2	21229
	f Healt f Healt ftem 2		Kathy Brady Da 20a. Method of Disposition	20b. Plac	e of Disposit	tion (Name of		Date		Baltimo	
٥	Pages nent of int: If it iry or o		KDXBurial 2 ☐ Cremation 3 ☐ R	emoval from State	etery, crema	tory or other pla		v 7/1	4/04	Pikesvi	.11e, MD
Baltimore,	permit. Page Department o Important: If eny injury or once.		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service ≰icense								
Ba	permit. DepartmImporta eny inju		1 / La H (A . C	- Bu	rgee-H	enss-	Seitz	Funer	al Home	Inc.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Do not enter	the mode of dy	ing, such as o	cardiac or re	spiratory arrest,	ne, no	Approximate Interval Between
	Dhusisian		Immediate Cause (Final								Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen		arker	Jaco	Carre			
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x 68	eath certificate attending phy i for use as the	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of pregnance	v					23d Date of do	in man
Вох	attenc attenc for us	lan	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 E	ctopic pregnand Other (specify) _	су			23d. Date of del	Day Year
o.	t the de by the tached	ysic	1 Yes 2 No	9 Unknown	001	J.(10. (apoony) _					
Ω.	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the		Part II. Other significant conditions con	tributing to death but not resulti	ng in the und	erlying cause g	iven in Part 1.		23e. Did tobacc	co use contribute to	the cause of death?
Records,	uires n sign lid be	d by							1 🗌 Yes	2 No 3 Pr	obably 4 Unknown
00	w require been si should t	Completed							24a. Was an	24b. Were au	itopsy findings available
Re	The lav	ЩC			-				autopsy performed 1 Yes 2	? death?	completion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical				26. Place		heck only one)	140	2010
<u> </u>	N S	ToB	examiner?	lospital: 1 Inpatient 2 EF	VOutpatient	3 DOA	ther: 4 🗆 Nur	rsing Home	5 Residence	6 Other (Spe	cify)
J of	ding Ph th. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Inju	ury at ork?	28d.	Describe how i	njury occurred	
jo	death. ctor: Af y the fur	atic	2 Accident investigation			M 1]Yes 2□N	No .			
Division	l or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office	Ð	28f.	Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
	itel o ras afi ral Di										
	the Hospitel or Attending hin 24 hours after death, the Funeral Director: After mpletely filled in by the fune	ical	(Check only 2 Medical Examin	sician: To the best of my knowle ner: On the basis of examination							
	To the Hospitel or Attentwithin 24 hours after dealt to the Funeral Director: completely filled in by the	Medical	29b. Signature and the of certifier	and manner stated.		29c. Licer	nse number		29d.	Date signed (Mont	h. Day, Year)
	No No No No No No No No No No No No No N		10/		7	36	569	24	.=	2.12.0	4
			30. Name and address of person who co	empleted cause of death (Item 2	3a) (Type, Po	rint)	4.5	/	7		,
	φ		Hunie Umo	idt H.D.S	ghes	herd's	Clin	ic, l	9015	+ faul	ST
S.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Spriatur	100	Ball	There	(Chu,	,2121	8	
	Registr	rar		1	1-1-0	- 40					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 July 12, **Physician** 2:08 P.M Mary Α. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville 7700 Oakleigh Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 23, 1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Mary Tand 83 Yrs. Director 212-18-7863 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director **Baltimore** Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 7700 Oakleigh Road Нете 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College,(1-4or 5+) than Elementary/Secondary (0-12) if Health and Mental Hygiene. Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Houdak Irving Jenkins Maryanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Buckleman-daughter 11832 N. 109th St., Scottsdale, AZ 85259 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery 7/14/04 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Baltimore, 21. Signature of Funeral Service Licensee William G. Dau Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Althe. ner /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2/2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed 1 Yes 2/No. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 No 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospitel or Attend within 24 hours after death To the Funerel Director; 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balthan, mo 6701 N. Charles (a) 4105 Kenneth M. Greene mo 31. Date filed (Month, Day, Year) 32, Registrar's Signature JUL 1 5 2004 Registrar

			1 - For State Registrar	State of Maryland	/ Depa		lealth and	Mental Hy	/giene Reg. No?	-	22207	
>	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Dorothea Fisher Ca 4a. Facility Name (If not institution, give s	rl		4b. City, Town, o	r Location of Dea		13, Day			
7	Funeral Director		12883 Hall Shop Ro 5. Social Security Number 298-03-7056 Usual Residence of Decedent			Highlane If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year)	vard 9. Birthp Cour New	elace (State or Foreign htry) York	
with the Maryland	th the Maryland or 28a-f show e notified at	Irector	10a. State 10b. County Maryland Howard 10e. Street and Number	10c. City, High1	Town or Loc	ation			10g. Citize	en of What Cour	0d. Inside City Limits 1 ☐ Yes 2 💆 No	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinat must be notified at once.	by Funeral Director	12883 Hall Shop Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ad 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes. 2 No If Yes. Give Year or Dates:	20777 Vas Decedent of H Yes, specify Cube		Specify Yes or N to Rican, etc.)		4. Race - Americ Black, White, Specify: Whit	etc.		
Maryland 21215-0036	filed within 72 ho Hygiene. other than "naturent, II w Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) aker			16b. Kind	d of Business/Ind			
ryland	should be file of Mental Hy marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) Edward Geither Fis 19a. Informant's Name/Relationship (Ty)	her	-		18. Mother's Na	Clara Bu	, <i>Maiden S</i> rgwar	en Sumame)		
	Pages 1 and 2 s nent of Health ar ant: if Item 27 is arry or other trau	Į.	Douglas Carl/son 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	20b. Plac	12883		p Road I	Highland, Maryland 2077 1y Date 20c. Location - City or Town, Si			0777	
Baltimore,	permit. Page Department Important: any injury once.	i	*4 □ Donation *5 □ Other (Specify) 21. Signature of Funeral Service Licen e Develop L. H. L.	W. A:		l Cremato Name and Addres ing Home verly L.				on, Mar	yland 784 MD 21029	
	Physician /Medical Examiner		Toolaing in doubly	cations that caused the death. e cause on each line. Cerebrovascula Due to (or as a consequer Hypertension	Do not ente	r the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death 24 hours	
8760,	icate be executed physicien and sthe burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate butto. Enter undarrying Cause (Disease or injury that initiated events resulting in death) Last b. HYPETENSION Due to (or as a consequence of): c									
.O. Box 6	death certif e attending d for use as	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of de ath 5 □ Other (specify)								ry Day Year	
Records, P	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac								e cause of death?	
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	Physician: rthis certific ral director,	0	examiner?	ospital:	/Outpatient	3□ DOA Othe	26. Place of Dea	ome 5 X Residence		704		
DIVISION OF	ling After	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be		b. Time of Injury	28c. Injury Work	at	28d. Describe				
Ž O	pital or urs afte eral Dir		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			o data and place	City or Tou	vn, State)	Vumber or Rural		
	To the Hos within 24 ho To the Functional Completely f	edical	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	and/or inve	estigation, in my op	inion, death occu	rred at the time,	date and pl	ace, and due to	ited. the cause(s)	
6	To the within 2 To the complet	Σ ν	29b. Signature and title of certifier	111		29c. License D2584				igned (<i>Month, D</i>	*	
7) Sta	te	30. Name and address of person into Servelyn D. Jackson M. 31. Date filed (Manth, Pay, Year)		aks R	oad Clar	ksville,	Mary1a	nd 210)29	,	
10	Registr		31. Date filed (Month, Pay Year)	place Is 1	0.347	9						

State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2000 M. ARR JORIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Northwest Hospital Center Randallstown | Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year) | Shirthplecs (St. County), Kentucky Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Months **Funeral** 1□ M 2 F 225-26-0433 79 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County I Hygiene. other than "neturel", or Itams 23e or 28e-f ehow vent, the Modical Examiner roast be notified at 1 Yes 2 No Md. Baltimore Reisterstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 619 Westminster Pike 21136 U.S.A. death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Marned be filed within 72 hours after 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Railroad Elementary/Secondary (0-12) Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I wit: If Item 27 is marked o David Price Bessie Carden 2 traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walter E. Carr - Husband 619 Westminster Pike, Reisterstown, Md. 21136 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or injury or Evergreen Mem. Gardens July 16,2004 Finksburg, Md. 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Fynal S 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. Name and Address of Facility 21117 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Md. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): **Examiner** EHAH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 4 🗸 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has page 2 2 No 1 🗆 Yes 1 Yes Vital the Hospitel or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 V No 2 ER/Outpatient 3 DOA 2 of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of D. ath Certification: After Division Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No м death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9 00041410 2004. M-thla M.O 13 0-0 min 4 30. Name and Indian of person who completed cause of death (Item 23a) (Type, Print) 15 61 N D CR P MEHTN RANDAUSTOWN HEIRIAN MO 21133 CENTER MINTHWEST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Carr Alma B. July 2, 6:30 A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8 Mira Court Baltimore Middle River 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Months Days 1 2 M 2 □ F Hours 94 Yrs. Director 236-05-5192 Usual Residence of Decedent with the Maryland Show 10a, State 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or items 23e or 28e-f show the Modical Examinar must be notified at Middle River Baltimore 1 ☐ Yes 2X XVo Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 United States 8 Mira Court death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel" or item any injury or other traument. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: ģ 35 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchant Sales 4 Years 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Rhoda Buzzard 2 Tom W. Carr 19a, Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Wanda Edwards/Daughter 8 Mira Court Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Tyler Mt. Mem. Gdns. 7/7/2004 Cross Lanes, WV 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. 21222 Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit and certificate be exec burial-t Due to (or as a consequence of): Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. E ☐Yes 2☐No detached he 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ The law requires i 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No page 2 2□ No 1 Yes 1 TYes Physicien: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: To 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospitel or Attending After 1X Natural 5 Pending investigation Injury after death.
I Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 6 Coufd not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year) ones D24334 7-14-2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayview Circle 21224 Baltimore, Maryland

DHMH 17 Rev 1/2001

Registrar

Thomas Finucane, M.D.

JUL 1 5 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** George Franklin Clark 556 PM 2004 12. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Darlington 1516 Castleton Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15M 20F 69 218-32**-**8234 26, Director 1935 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Darlington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21034 **USA** 1516 Castleton Road or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Yes. Give 3 XWidowed 4 ☐ Divorced Year or Dates: "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) rthan Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If item 27 Is marked other thus any injury or other treumatic event, That once. 12 Test Driver U.S. Government 18. Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cora Elizabeth Reeves George Lewis Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen F. Clark/Son 321 Conowingo Road, Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donalion 5 ☑ Other (Specify) Dublin Southern Cem. 7-16-04 5 Other (Specify) Darlington, MD eral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signatu 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death Part. Ther the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown δ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be 2 X No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 Yes 2 No certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one, Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 1000 14206 npleted cause of death (Item 23a) (Type, Print)

KNA MD, DME 7018 HOLABIRD AVE BALTO INC 32. Registrar's Signature State Registrar

				artment of Health and M rtificate of Death	Re	g. No) 1 1 2 2 2 1 1						
	Physici /Medi		1. Decedent's Name (First, Middle, Last) ROBERT LEE DEATON SR.		2. Date of Death Month JULY	Day Year 2001 1443 M						
	Examir		4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY						
	Funeral Director		5. Social Security Number 215-30-3840 6. Sex 1 X M 2 F 68 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, SEPT 25	- //						
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
	th with the 23a or 28s	al Director	10e. Street and Number 23138 TALBOTH DRIVE	10f. Zip Code 19958	1	ng. Citizen of What Country? NITED STATES						
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "naturel", or items 23s or 28a-f show other traumatic event, If a Marical Examination to Intelliged at	by Funeral	1 Never Married 211 Married 1 1 Yes 2 121No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE							
21215-0036	d within 72 ho giene. Ir then "natur Ire Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workir DO NOT use retired) FRICAL ENGINEER	ng	5b. Kind of Business/Industry DEFENSE/MANUFACTURING						
Maryland	should be filed nd Mental Hygi marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) HERBERT T. DEATON	aiden Sumame)								
	t and 2 sho fealth and im 27 is m ther treum			ng Address (Street and Number or Rural TALBOTH DRIVE LI	EWES, DE	LAWARE 19958						
Baltimore,	Page ment c ant: M ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	DGE MEM. PK. 2004	E	0c. Location - City or Town, State LKRIDGE, MARYLAND						
Ba	Departi Departi Importi any inji		Du L Chavy 42	CREEY ARUDDICK'Y FUNE COLORAIN HIGHWAY S.	E. GLE	N BURNIE, MARYLAND						
,	Pnysician /Medical		23a. Part1. Enter the disease, or complications hat caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		respiratory arres	Interval Between Onset and Death						
	Examiner	ner	Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury	CANCER								
8760,	cate be executed physician and the burial-transit	dicai Examiner	resulting in death) Last C. CONTROL TO THE PROPERTY OF THE PR									
O. Box 6	death certifi e attending ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year							
rds, P	ires sign 1 be	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the cause of death?						
al Record	The law ate has b page 2 s	Completed			24a. Was an autopsy performe							
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death		ce 6 ☐ Other (Specify)						
	fing After fune		27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 2 Accident 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)		3d. Describe how							
Division	i Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)		City or Fown,							
	Fur Fur stely	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invalid and manner stated.	осситеd at the time, date and place, ar restigation, in my opinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)						
)	To the within 2 To the complet	S	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)						
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, I			LLY 10 2004						
	Sta	te	FAITO AMJAO ZOI EAST UNIVERSITY AN 31. Date filed (Month, Day, Year) 32. Registrar's Signature A	ARKWAY BALTIMOR	E MO	2/2/8						
4	Registr	ar	JUL 1 5 2004 Jenus	sports								

		For State Registrer	State o	f Maryland		artment of I tificate of		and M		giene Reg. Ne	nn	Carriage and P	22212
Physici /Medic			an						2. Date of De Month JULY	Day	, 200	Year	3. Time of Death 11:16a
Examir	ier	4a. Facility Name (If not institution, given 4505 BELAIR ROAD	e street and nui	mber)		4b. City, Town, o				4c. County of Death			
Funeral Director		5. Social Security Number 222-30-9708 Output 6. Sex 1		If Under 1 Year Months Days	Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Year) Aug 11, 1946			Birthplace (State or Foreign Country) Delaware			
h the Maryland r 28a-f show r polified at	tor	10a. State 10b. County MD N/A		10c. City, 1 Ba]	Town or Lo								Od. Inside City Limits
th with the 23s or 28a ust be noti	Funeral Director	10e. Street and Number 4505 Belair Road				10f. Zip Code 21206		10g. Citi	zen of Wh	at Coun			
36 s after death with , or Itams 23c or	by Funera	11. Marital Status 1 Never Married 2 Married	Armed Fo	2 X] No ∕e	1	Vas Decedent of H Yes, specify Cub	lispanic Orig an, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	White, e	etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland thand Mental Hyglene. Ith and Mental Hyglene and the filed within and Mental Hyglene at 18 marked othar than "natural", or Itams 23c or 28a-1 show traumatic event, the Medical Exammer at missise notified at	Completed b	3 ☐ Widowed 4 ② Divorced 15. Decedent's E (Specify only highest grave) Elementary/Secondary (0·12)	Year or Diducation ade completed) College (1	1	6a. Deced (Give	ent's Usual Occup kind of work done OO NOT use retire	pation during most d)	of worki	ng	16b. Kir	nd of Busi		ustry
rre, Maryland 2121 s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me	Be Con	8 17. Father's Name (First, Middle, Last)	10.07	Gra	ve Digge	18. Mother		(First, Middle,	Maiden	meter Sumame)		
Aaryla 2 should I and Men Is marke	T _o	19a. Informant's Name/Relationship (r or Rura		per, City or Town, State, Zip Code)			Code)
Fe, s 1 ar if Hea item otha		Melissa Huddlest 20a. Method of Disposition 1 Burial 2 Cremation 3 E		20b. Place ceme	e of Dispos etery, crem	Fincher I lition (Name of latory or other place	ce)	D	ate	20c. Lo	567 cation - Ci		
Baltimo permit. Page Department of Important: If any injury or		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lie	y) 7 ^{ee}	Ches	22	Crematory VFA [®] , and Addre	shen B	. Lo	'2004 hrmann		tsvil	le,	MD
Filysician /Medical Examiner	_	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a 1-the	aused the death. [ach line.	Do not ente		ig, such as c	cardiac o	r respiratory ar	rest,	owson		21286 Approximate Interval Between Onset and Death
ob/ou, ilicate be executed g physician and as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C										
death certif	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	come of pregnancy irth 2 Fetal de ant at time of death	ath 3 🗆	Ectopic pregnancy Other (specify)				23	3d. Date o Month		/ Pay Year
law requires that the as been signed by the should be detached.	by	Part II. Other significant conditions of		A	not resulting in the underlying cause given in Part I.								cause of death?
The ate his page	Completed								24a. Was a autop: perfor 1 2 Yes	sy med?	dea	re autops r to comp th? Yes 2	sy findings available pletion of cause of
ng Phy ng Phy fiter this	lon; To Be	25. Was case referred to medical examiner? 1 X 9ss 2 □ No 27. Manner of Death √ Natural 5 □ Pending	Outpatient o. Time of Injury	28c. Injun Work	er: 4 □ Nurs at c?	sing Hom	(Check only or le 5 Reside 8d. Describe he	ence 6		(Specify)	SCENE		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At home, ig, etc. <i>(Specify)</i>	farm, stre		Yes 2∏N	-	8f. Location (Si City or Town	treet and n, State)	Number o	or Rural I	Route Number,
To the Hospital Within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1☐ Certifying Ph (Check only one) 1☐ Certifying Ph 2☑ Medical Exen	ysicien: To the niner: On the ba and mann	best of my knowled sis of examination er stated.	ige, death and/or inve	occurred at the timestigation, in my op	ne, date and pinion, death	place, ar occurred	nd due to the c	ause(s) a late and p	and manne place, and	er as stat	ed. ne cause(s)
To the within To the comp	2	29b. Signature and title of certifier Joshan	Theer	s rip		29c. License OCM			2		signed (NY 04,		
		30. Name and address of person (a) or Tasha Z Cir	eenber	F.a	111	Penn St	reet,	Balt	imore,	Mary	yland	212	201
Stat Registra	_	31. Date filed (Month, Day, Year) JUL 1 5 2004	Sener S	gistrar's Signature	Sp	acti							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) July 13 2004 **Physician** Disque 5:50 A'M Catherine /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery National Lutheran Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 💢 F 81 Yrs. 577-20-3294 28, 1923 Washington DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location or 28a-f show r than "natural", or Items 23a or 28a-1 showing Medical Examiner must be notified at 1 ☐ Yes 2 No Kensington Be Completed by Funeral Director Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 United States 2701 Calgary Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 21X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 is marked other taury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pear1 Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer Disque / Husband 2701 Calgary Ave., Kensington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) July 14 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Funeral S Stephen Johnson 933 Gist Ave., Silver Spring, MD M00382 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician PULMONARY disease or condition FIBROSIS FIELD MONTHS /Medical resulting in death) Due to (or as a consequence of): Examiner ARDIAL ARRHYTHMIA Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury anding physician and use as the burial-transit The law requires that the death certificate be executed CONGECTIVE HEART that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical HYPER TEN SION IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 Yes Vital Hospital or Attanding Physician: After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Division of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death Diractor: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours 2 To the Funaral 29a. Certifier Medical 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wherline 20051158 2004 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKUILLE MO20850 VATTI-T. ANTHONY 9701 VEIRS DRIVE 11.0 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JUL 1 5 2004

ORIGINAL

			State of Maryland / De	epartment of Health and M Certificate of Death	•	2001. 22211.
	Physici	an	Decedent's Name (First, Middle, Last)		2, Date of Death Month	3. Time of Death
	/Medic		Lewis J. Darter, Jr.			11 2004 12:45 PM
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Rockville		4c. County of Death
			Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe		9 Date of Birth	Montgomery
Н	Funeral Director		216-44-9781 1X M 2 F 96 Yr.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. Aug. 22,	ar) 9. Birthplace (State or Foreign Country) Kentucky
			Usual Residence of Decedent		Hug. 22,	1707 Renedeky
	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow lical Examinar must be notified at	_	10a. State 10b. County 10c. City, Town of			10d. Inside City Limits
	Ba-f	cto	Maryland Montgomery	Bethesda		1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number 8909 Grant St.	10f. Zip Code 20817		Citizen of What Country?
	sath w	era	11. Marital Status 12. Was Decedent Ever in U.S.			nited States 14. Race - American Indian,
	fter d	E.	1 Never Married 2 Married 1 Mayes 2 No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 	Rican, etc.)	Black, White, etc.
036	hours af turai', or	ρ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: W W II	1 ☐ Yes 2 ☒ No Specify:		Specify: White
21215-0036	72 ho natur	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (0	ecedent's Usual Occupation	16b	Kind of Business/Industry
21	d within giene. ir then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Rive kind of work done during most of working DO NOT use retired)		1 1 0
12			17. Father's Name (First, Middle, Last)	Archivist	(First, Middle, Maio	ederal Government
and	Q	o Be	Lewis J. Darter, Sr.	Pauline		vine
Σ	s 1 and 2 should be if Health and Mental. If Health and Mental. Item 27 is marked oother treumatic eve	2	19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Number or Rura	l Route Number, Cit	y or Town, State, Zip Code)
N	a. a a a			9 Grant St., Bethes		0817
J.e.	ss 1 and 2 of Health litem 27 r other tre	1 1	20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place) n, Memorial July	14, 20c.	Location - City or Town, State
<u><u>E</u></u>	permit. Pages Department of H Importent: If ite any injury or of once.		1 X Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Gai	n Memorial July dens 20		ilver Spring, MD
Baltimore, Maryland	permit. Departr Import any init		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rapp Funeral and Cr		
	<u>vo</u> = 4 a		23a. Part1. Ener the disease, or complications that caused the death. Do not	933 Gist Ave., Silv	er Spring	, MD 20910 Approximate
	Physician /Medical Examiner	ner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listesse of Irigin y that initiated events C.			Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	edical Examiner	Caues (Disease or Influid that initiated events resulting in death) Last C. Due to (or as a consequence of) d.			
P.O. Box 6	equires that the death certificate sen signed by the attending phys tould be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	s that gned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rd	w require been sig should b	ed	Status Post Colostomy		1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	The law rate has be	Completed			24a. Was an autopsy performed′	24b. Were autopsy findings available prior to completion of cause of death?
/ita	cian: extific	Be	25. Was case referred to medical examiner?	26. Place of Death		
of	Physi this c	.T	1		ne 5 Residence 28d. Describe how in	6 MOther (Specify) Hospice
on	ding F h. After funera	tion	1 XNatural 5 ☐ Pending (Month, Day Year) Inju		od. Describe now in	jury occurred
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	he Hospitel n 24 hours a he Funerel D bletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, of the basis of examination and/of and manner stated.	eath occurred at the time, date and place, a ir investigation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the To the complet	ž	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
•	- 1/1		Eddler	041218	7	412/04
_	541		30. Name and address of person who completed cause of death (Item 23a) (Ty Charles Harrison M.D.; 6001 Muncas		ille, MD	20852
	Sta Registr	- 1	JUL 1 5 2004 32. Registrar's Signature	books		

			1 - For State Registrar	State of Maryla	and / Depa		t of H	ealth ai				22215	
п	Dhuniai		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death	
	Physici /Medi		CLEORA	JULY 13	-		1:10 pm M						
	Examir	er	4a. Facility Name (If not institution, give		ounty of Deatl								
			RESIDENCE				BA	LTIMO	RE	NA.			
0	Funeral		5. Social Security Number 6. Se	x 7. Age (In y ☐ M 2]X☐ F	rs. last birthday)	If Under Months	1 Year Days	II Under 24 Hours	Min. 8. Date of Bit (Month, Da	th ly, Year)	9. Birth	nplace (State or Foreign untry)	
	Director		Usual Residence of Decedent	3 24.	62 Yrs.				DEC 19.	1941		MD	
	land	10.00											
	Mary interp	ō	ND 37									10d. Inside City Limits 1 X Yes 2 □ No	
	the 28a	Tec.	MD NA 10e. Street and Number	A	BA	LTIMC 10f. Zip				10a Citizer	n of What Co	untry?	
	3a or		2503 VIOLET AV	JENUE APT# 9	907 SOUT	1		215		reg. emile.			
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in					n? (Specify Yes or No Puerto Rican, etc.)	- 14.	USA Race - Amer	ncan Indian.	
9	after or Ita	큔	1 Never Married 2 Married	Armed Forces?	1				Puerto Rican, etc.)		Black, White	RICAN	
8	72 hours after deeth with the Maryland Instural', or Itams 23a or 28a-f show Libsal Evantains must be positived at	1 by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2	No No	Specify:		Sp	AMER		
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anc	be fi	Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Middle,	Maiden Su	mame)		
2	should nd Mer marke umatic	^c	DAVID FOSTI						MATTIE	BOWEN			
Maryland 21215-0036	0 4 4		19a. Informant's Name/Relationship (Ty		19b. Mailir	g Address	(Street a	nd Number (or Rural Route Numbe	er, City or To	own, State, Zi	ip Code)	
	1 and Health em 27 ther t		ROOSEVELT DICKEY 20a. Method of Disposition	(SON)	703 . Place of Dispo	RADNO		VE_BAI	LTIMORE, M.		-	4.4.64	
סַר	Pages nent of int: If Its iry or o		1 Burial 2 ☐ Cremation 3 ☐ P	lemoval from State	cemetery, cren	natory or ot	her place	1			ion - City or T		
Baltimore,	it. Partitude intentional injury		'4 □ Donation 5 □ Other (Specify)		. Zion			1	-16-04		lowne,		
Bal	Depa Depa Impo Impo Impo		21. Signature of Funeral Service Licens	1/1/1/					WYLIE FUN				
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J.	that ed by deta		Part II. Other significant conditions con	tributing to death but not n	esulting in the un	derlying ca	use giver	n in Part I.	23e. Did to	bacco use d	contribute to t	the cause of death?	
ds	w requires that been signed I should be det	d by							1 🗆 Y	es 2 12 N	o 3 ☐ Proi	bably 4 Unknown	
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		\vdash	27. Manner of Death	1 ☐ Inpatient 2	ER/Outpatient		c. Injury	`4 ☐ Nursii	ng Home 5 PResid	ence 6 🗆	Other (Specia	fy)	
0	ding h. After fune	tlor	1 Natural 5 Pending	(Month, Day Year)	Injury		Work?	,	Edd. Describe in	OW IIIJary OC	Currey		
=	or Attending after death. Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place ol Injury - At building, etc. (Spec	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury · At home, larm, street, lactory, office building, etc. (Specify)						umber or Rura	al Route Number,	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Certifier 2 Medical Examination (Check only one)	ncian. To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred a estigation, i	t the time in my opii	, date and p nion, death o	niace, and due to the coccurred at the time, c	ause(s) and late and plac	manner as s ce, and due to	stated. o the cause(s)	
	To the To the To the Comp	Me	29b. Signature and title of certifier	4.4.4			License		2	9d. Date sig	gned (Month,	Day, Year)	
Y			· everjanson	W/ MID		D,	1661	9		JULY	14, .	2004	
	18		30. Name and a dre's ol person who con	mpleted cause of death (It	em 23a) (Type, F	Print) VI< cie	v s	QUA	RE DR. 6	BALTIK	PORE	2004 MD. 21236	
	Sta Registra	701	31. Date filed (Month, Day, Year) JUL 1 5 2004	Registrar's Sign		de p							

			For State Registrar	State of M	aryland		artment of H		and M		iene 19. N. 0 0 4	22216
			1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	h Day Yea	3. Time of Death
	Physici /Medic		Maryanna F.	Dregier						Annual Property Control of the Contr	12-04	
	Examin		4a. Fecility Name (If not institution, give s				4b. City, Town, or	Location o	f Death		4c. County of D	
	,,, , , , , , , , , , , , , , , , , ,		Manor Care Ruxto		a (In our In	and to instruction of	Ruxton If Under 1 Year	If Under	24 Hrs	8. Date of Birth	Baltir	
	Funeral Director		5. Social Security Number 219-10-3774 6. Sex	M 2 XF 7. AG	je (In yrs. la 77	Yrs.	Months Days	Hours	Min.	Aug. 15	Year) 1926	Birthplace (State or Foreign Country) Maryland
5	D		Usuet Residence of Decedent									
	arylar show	_	Md. Baltimor	Δ.		Town or Lo thervi						10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	he Ma	ecto	10e. Street and Number	C	Lu	CHEI VI	10f, Zip Code			1/	Og. Citizen of What	
	with with the party of the part	Funeral Director	1209 Oakcroft D	r.			21093				-	SA
	TIS 23	era		2. Was Decedent	Ever in U.S	. 13.	Was Decedent of H	ispanic Orig	gin? (Spe	cify Yes or No-	14. Race - A	merican Indian,
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖄 If Yes, Give	No		f Yes, specify Cuba 1 □ Yes 2 💆 No	Specify:	i, Puerto r	nicari, etc.)	Black, W	
8	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:							SpecifiWh.	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow In Mudical Exerciter mast be rollifed at	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most	t of working	ng	16b. Kind of Busine	ss/maustry
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yla	should be filed within and Mental Hygiene. marked other than " umatic event, tre Men	T _o	Michael Michn			405 14 77			leghi			- To Codel
Maryland	d 2 sho th and th sm traum		19a. Informant's Name/Relationship (Ty) Mr. Daniel Dregier	_	on		-				City or Town, State	
ē,	is 1 and 2 of Health ar item 27 is other trau		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	1		-	20c. Location - City	
E	Pages sent of int: if iry or		1 X Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	St.	Stani	slaus Cei	m.	7-14-	-04	Baltimore	e, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any hjury or other traumatic event, II.a Medical Examinating man be collided at QRGs.		21. Signature of Fynaral Thrvice Licente			22	Name and Address 1050 You	ss of Facility WSON CK Rd	Funer Tov	ral Home	Inc 21204	
	7		23a. Part1. Enter the disease or complishock, or heart failure. List only or	cations that cause le cause on each I	d the death.							Approximate Interval Between
de l	Physician		Immediate Cause (Final disease or condition	Prosy	lesson	ne s	SuPnan	ucle	ear	Pals	4	Onset and Death
Н	/Medical Examiner		resulting in death)	Due to (or as	a consequ					_		
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8760,	cate b physic the b	d										
9 x	Se ip	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome							23d. Date of	delivery
Box	death of atten	Iclar	in the past 12 months?	1☐Live birth 4☐Pregnant a]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day Year
P.0	that the ded by the detached	hys	9 Unknown	9L Unknown								
	es De	by	Part II. Other significant conditions cor	tributing to death t	out not resu	lting in the u	nderlying cause giv	en in Part I.				e to the cause of death? Probably 4 (Dunknown
orc	v requir been si should	eted		· · · · · · · · · · · · · · · · · · ·		<u> </u>						
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Vital		ပိ	25. Was case referred to medical					os Diace	of Death	(Check only one	1 DY	es 20 No
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sior	oat or:	catlo	2 ☐ Accident investigation					Yes 2□I				
Division	i Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ijury - At hor tc. <i>(Specify)</i>		eet, factory, office		2	28f. Location (Sti City or Town	reet and Number or , State)	Rural Route Number,
	Hospitel 24 hours a Funeral I stely filled	Medical (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best ner: On the basis of and manner s	of examinati	vledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, a	and due to the ca	use(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	1			29c. Licens				9d. Date signed (Me	
)	/		1222 C	-	e.	pre	. HOO	544	24		7-12-	04
	h		30. Name and address of person who co	mpleted cause of	death (Item	23а) (Туре,	Print)	- 0	0 -	_	7-12- m, MD.	01-0-
	J		Grus Asadi/2	0 E. 711	moni	um	rd. Suit	exc	7 /	Moniu	m, MD.	21013
16	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 5 2004	32 Hegist	trar's Signat	G	Sour.	,				

			For State Registrar	State of	Marylan	_	artment of rtificate of		d Mental Hy	giene)4	22217
	00		Decedent's Name (First, Midd.	le, Last)			<u> </u>		2. Date of De		Year ı	3. Time of Death
	Physicia /Medic		Jay D. Dunca				T.,		July	12 0	200-	6:00 M
	Examin	er	4a. Facility Name (If not institutio	n, give street and num	1 A.		4b. City, Town,	A:	eath /	4c. County	y of Death	cd
	Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi	rth	9. Birthp	place (State or Foreign
	Director		220-18-8772	1 ⊠ M 2□F	79	Yrs.	Month's Days	riours	Mar.	30, 1925	Nort	h Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	/, Town or Lo	ocation				1	0d. Inside City Limits
	Mary 9-1 sh	tor	Maryland Harf	ord		Bel A	ir					1 ☐ Yes ¾XNo
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	ntry?
	death with the Maryland ms 23e or 28e-1 show rmst be notified at		2004 Highland		dent Ever in U.	S. 13.		L015 Hispanic Origin	? (Specify Yes or No		USA ce - Americ	an Indian,
(C	5 2 2	Funeral	1 ☐ Never Married 25 Mar	Armed For	ces?		If Yes, specify Cul		? (Specify Yes or No Puerto Rican, etc.)	Bla	ck, White,	etc.
003		d by	3 Widowed 4 Divorced	Year or Da	e ites:					Specif		White
<u>r.</u>	n 72 hours "natural",	Completed	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of ed)	f working	16b. Kind of B	iusiness/Ind	dustry
21.2	d within giene. or then "	mo:	Elementary/Secondary (0-12)	College (1	-4or 5+)	Carr	enter			Cabin	etmak	er
2	be file atal Hyg od othe event,	Bec	17. Father's Name (First, Middle,	, Last)		-		18. Mother's	Name (First, Middle	, Maiden Surnar	me)	
Maryland 21215-0036	and 2 should be filed within 72 h. Health and Mental Hygiene. It then the filed years to the filed years to the filed years to the filed other traumatic event, the Medical	2	Flake Evans 1			19h Maili	na Address /Stree		ude (u/K) or Rural Route Numb		State Zin	Code)
2	nd 2 sh lith and 27 ts r		Hazel N. Dune)			Bel Air,			Code)
9	s 1 and 2 of Health item 27 r other tra		20a. Method of Disposition		20b. P	al inter-	osition (Name of matory or other pl		Date	20c. Location		own, State
i	Page ment cant: If		1 □ Buris 2 □ Cremation 4 □ Do Ation 5 □ Other		state	Grove	Baptist	Cem.		Bel Ai	r, Ma	ryland
Raltimore	permit. Pages 1 Department of F Important: If ite any injury or ot		21. Sign Jurg of All all Service	Lice see	17	Î.	Name and Addi ICCOMAS I 50 W. Bro	ess of Facility Funeral Dadway S	Home, P.A St., Bel A	ir, MD	21014	
1			23a/Part I. Enter the disease, of shock, or heart failure. Lis	or complications that can only one cause on e	used the death	n. Do not en	ter the mode of dy	ing, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	10	Immediate Cause (Final disease or condition resulting in death)	a(lcute	_ K	espira	Tory 1	taifure			days
W	/Medical Examiner		resulting in death,	Due to (or as a consequ	uence of):	00000	- d	Fulling			months
4		Jer	Sequentiary list conditions, if any, leading to immediate	Due to	s a consequ	uence of):	Julia	7	anjuu			P
Ca n	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	CL	alhrel	io, li	of 8 Hori	L		months
UN C	ate be executed hysician and the burial-transit	cal E	7000Aing in double, East		a consequ	aerice org.	0.5	order	U			months
72	ificate g phys	ed		0.	7-	- V		7,100				
, ,	eath certifice attending ph	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregna irth 2 Petal		⊒Ectopic pregnan	су			ite of delive	nry Day Year
	ne death the atte	yslcl	1 Yes 2 No	4□Pregn 9□Unkno	ant at time of de wn	∍ath 5[Other (specify)				27.01	Day Fou.
3/2	that the de led by the detached	y Ph	Part II. Other significant condit	ions contributing to de	ath but not resu	ulting in the u	inderlying cause g	iven in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
0	v requires tha been signed I should be det	ed by	Cache	XIa.					_ 1 🗆	Yes 2□No	3 🗆 Prob	ably 4 Unknown
Division of Vital Become	Attending Physician: The law requires that the death certifics redault. ector: After this certificate has been signed by the attending physithe funeral director, page 2 should be detached for use as it.	Completed							24a. Was auto perfo	omed?	death?	psy findings available inpletion of cause of
-	ding Physician: The h. After this certificate h. funeral director, page	BeC	25. Was case referred to medical examiner?	al				26. Place of	Death (Check only			
> >	hysic this ce al dire	ို	1 ☐ Yes 2 No			ER/Outpatie	nt 3LIDOA		ng Home 5 Res			1)
2	ding P h. After funera	tlon	27. Manner of Death 1 Natural 5 Pendi	ing 28a. Date of (Mont)	h, Day Year)	28b. Time o Injury	W	uryat ork?]Yes 2∐No		how injury occur	Ted	
i vici	- 755-	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At ho ng, etc. (Specify	ome, farm, st	reet, factory, office	•	28f. Location (City or To	Street and Numb wn, State)	ber or Rura	l Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifyi	ing Physicien: To the I Examiner: On the ba	best of my kno	wledge, deat	h occurred at the	time, date and p	place, and due to the	cause(s) and made	anner as sta	ated.
_	Fo the H within 24 Fo the F complete	Medical	one) 29b. Signature and title of contifu	and manr	ner stated.			ise number		29d Date signe		
	D		30. Name and address of person	o who completed cause	of death (Item	W. D	Print)	- 00	18779	July	13,	2004
	0		ALBERT S.	SUN, MI). 17	16 H	arford 1	Road, S	te.105,	fallsto.	n, MI	021047
	Sta Registi		31. Date filed (Month, Day, Year	7) 32. R	egistrar's Signa	ture	le le					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	arylan		artment rtificate					giene	n L	22210
			1. Decedent's Name (First, Middle,	Last)						2	2. Date of Dea	ath Day	Voor	3. Time of Death
	Physici /Medic		Doris R.	Earle							July	12	200	1805 M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City,	Town, or L	ocation o	of Death		4c. County	y of Death	
			St. Ugnes H	ealthCar			Bal	111	016				N/A	
	Funeral			3. Sex 7. A 1 □ M 3 X □ F	-	last birthday) 27 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birt (Month, Da	y, Year) 5,1922	9. Birthp	lace (State or Foreign
	Director		215-14-8699	- A		32 Yrs.				h.	une 2	5,1922	Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Maryłan f show	ō	Maryland N/A	٨		Rolt	imore							1∭Yes 2 □ No
	the 286	rect	10e. Street and Number	7		рате	10f. Zip					10g. Citizen of	What Cour	itry?
	3a or	<u></u>	3320 Benson Ave	eniie				2.	1227			USA		
	death ms 2	Funeral Director	11. Marital Status	12. Was Deceden		.S. 13.	Was Deced				fy Yes or No- can, etc.)		ce - Americ	
9	after or its	Ē	1 Never Married 2 Marrie	Armed Forces d 1 ☐ Yes 2 ☑ If Yes, Give					Specify:		Garr, etc.)	200	ck, White,	
933	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show dical Expordrer must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates			1 ☐ Yes 2	X	эроспу.			Specif	y. Wh	ite
215-0036	72 h "natu	Completed	15. Decedent's (Specify only highest			(Give	dent's Usua kind of wor	k done dui	ion <i>ring m</i> os	at of working	1	16b. Kind of B	usiness/Ind	dustry
2	within ene. then "	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)	Secre	DO NOT us	e retirea)				High	Saboo	.1
121	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Li	ast)		DECLE	cary	1	8. Mothe	er's Name (First, Middle.	Maiden Sumar		<u> </u>
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 Ie marked other then "natural", or Items 23a or 28e-1 show other treumetic event, the McAlical Exprimer must be notified at	Be c	Gilbert Re								ster G			
Z	2 should and Me le mark eumeth	2	19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street and	d Numbi			r, City or Town,	State, Zip	Code)
\mathbf{z}	nd 2 strict		Gerald L. Earle			1	-					mington		
ō,	Health tem 27 other tr	1 1	20a. Method of Disposition	7 5011	20b. F	Place of Dispo	sition (Nam	ne of		Da		20c. Location	•	
OLL	Pages nent of int: If it		1 ☐ Burial 2 🎇 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	B ☐Removal from State	9	ro Cre	-			07/1/	/O/i	Baltim	ore.	MD
Baltimore,	그 돈 만 쓴		21. Signature of Funeral Service Li	censee	12100	22	. Name and	d Address	of Facili	ty			-	
ñ	Departing Important any response	į š	Thomas Gregor	7		1 9	remat	ion S	Soci	ety 0	f Mary Baltim	land In ore, MD	c. 212	28
	-		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the deat									Approximate Interval Between
	Physician	ŭ.	Immediate Cause (Final			50	004							Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or a		uence of):	JCK							Hours
	Examiner		Casuantially list conditions	, PNE	um	ONIC							U	nknown
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or a	s a conseq	uence of):								
	nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
, O	sate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):								
8760,	death certificate be executed e attending physician and od for use as the burial-transii	Physician/Medical	•	d										
9 ×	that the death certifici ed by the attending pl detached for use as t	/Me	IF FEMALE:	23c. If yes, outcom	e of preons	ancv						224 Da	4 6 - d - livro	
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Feta	Ideath 3	Ectopic pre						te of delive onth	Day Year
P.O.	the de	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	21 (11110 01 0	02	J Carlor (Spa							
	res that signed by be deta		Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying ca	ause given	in Part I		23e. Did to	bacco use cont	tribute to th	e cause of death?
ds.	uires sign ld be	Q P	PYELONEPH	RITIS					_		1 🗆 Y	es 2 No	3 🗌 Prob	ably 4 Unknown
Ö	w requir been si should	lete	DEHYDRAT								24a. Was a	an 24b.	Were autor	osy findings available
Re	The law requires that the site has been signed by the bage 2 should be detache	Completed by	DUITURATI	070							autop	med?	prior to con death? 1 □ Yes	npletion of cause of
Division of Vital Records,		Φ	25. Was case referred to medical	T				2	26. Place	of Death (1 □ Yes Check only o		1 1 1 1 1 2 3	20 140
<u> </u>	Phyelclan: this certificatal director, I	To B	examiner?	Hospital: 1 ☐ Inpat	tient 🖎	R/Outpatien	it 3□ DO	Other				lence 6 Oth	er (Specify)
0	g Ph ter th peral		27. Manner of Death	28a. Date of In (Month, D	jury av Year)	28b. Time of	25	8c. Injury a Work?	it	28	d. Describe h	ow injury occur	red	
0	Attending ir death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investiga	ition			М		s 2 🗌	No				
Ĭ	r Atterder de l'recte	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of I	njury - At ho	ome, farm, str	eet, factory	, office		28	f. Location (S City or Tow		per or Rura	Route Number,
	urs after or ral Dir.													
	Hosp 4 hou Fune ely fii	edical	(Check only 2 Medical E	Physician: To the bes xaminer: On the basis	of examina									
	To the Hospitel or Attending Phyeiclen: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	one) 29b. Signature and title of certifier	and manner s	SIZIEG.		29c	. License n	number			29d. Date signe	d (Month, L	Day, Year)
	- X - S									_				
	*		30. Name and address of person w	my du man the sompleted cause of sail per m.	death (Item	n 23a) (Type	Print\	126	6 4			ر الم	C	7
	v \		Terome Is	Junpictor cause of	D . C	20 500	TUP.	A-70:0	0	alize l	BALTIE	non = M) AD W	AND 2/229
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ature	~ r_1-[_C/	I JUJU	1100	/VWL- 1	J. m. 1 1 1 1	10155	11/5/	
	Registi		JUL 1 5 201	14 Seper	na	6	Low	61						

DHMH 17 Rev 1/2001

ORIGINAL

			For Amend Item #26 per physicand / Pepsyment of Health and N 1- Registrar Certificate of Death	lental Hyg	•	0
5			Decedent's Name (First, Middle, Last)	2. Date of Deat	Serve Come Every	<u> </u>
	Physic		Willard Henry Ebberts Jr.	Month July	Day Year	
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	o ary	11 2004 10:53	
	LAGIIII		North Arundel Hospital Glen Brich	P	Anne Arundel	ř
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birthplace (State or Fo	oreian
	Director		220-70-0690 1 M 2□F 47 Yrs. Months Days Hours Min.	Feb. 13	Country) , 1957 Maryland	
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		-	
	sho	5			10d. Inside City L 1 ☐ Yes 2	
İ	the N	Directo	Maryland Anne Arundel Severn 106. Street and Number 10f. Zin Code			7140
1	and 21215-UU36 be filed within 72 hours after death with the Maryland hat hygiene. sd other than "natural", or itams 23a or 28s-f show event, the Medical Examinar must be notified at		10f. Zip Code 8227 W B&A ROAD 10f. Zip Code 21144		0g. Citizen of What Country?	
0	death ms 2%	Funeral			UNITED STATES 14. Race - American Indian,	
8	or ita	교	Armed Forces? If Yes, specify Cuban, Mexican, Pueno 1 □ Never Married 2 □ Married 1 □ Yes 2 Σ No	Rican, etc.)	Black, White, etc.	
Villar	ral', o	by	3 ☐ Widowed 4 X Divorced If Yes, Give 1 ☐ Yes 2 No Specify:		Specify: WHITE	
5	215-UU36 thin 72 hours aft e. an "natural", or Medical Exami	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ina	16b. Kind of Business/Industry	
3	vithin 72 ene.	I du	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CUISTOD TAN	9		
	d 212 filed with Hygiene other tha		COSTODIAN	- (First 14) (4)	JANITORIAL	
7	and the f	Be	17. Father's Name (First, Middle, Last) WILLARD HENRY EBBERTS SR LAURA C		Maiden Sumame)	
3	laryland 2 should be fill and Mental Hy is marked oth surnatic even	ှင	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Poute Number	City or Town State Tin Code)	
9:	and 2 seath ar n 27 is		IAUDA EDDUDEG GEUDDG MOEURD			
7.	Fe, Head them stem stem stem stem stem stem stem st		20a. Method of Disposition 20b. Place of Disposition (Name of	And the last of th	AND 21144 20c. Location - City or Town, State	
J	Pages Pages nent of I int: If its		1 Surial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) CTEN HAVEN MEMORIAL.	1 ¹⁵ ,	GLEN BURNIE, MARYLA	ND
3	baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es		21. Signatur Funeral Service Licensee 21. Signatur Funeral Service Licensee 22. Name and Address of Eacility FUN			112
C	n age a		ful Libourg 421 CRAIN HIGHWAY S			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arre	st, Approximate Interval Between	
	Priysician	n .	Immediate Cause (Final disease or condition Acute Mycaca Oial A	1 Race		'n
	/Medical		resulting in death) Due to (or as a consequence of:			
1	Examiner		Sequentially list outsitions b. Wichetes 1/21/1/20	1		
Pa	ed sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	xecut and al-trar	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
, i	The faw requires that the death certificate be executed. The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	70				
	ificate g phy as the	edic	d			
	BOX OR Boath certifica attending ph for use as th	N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
۵	Cords, F.C. Box or we require that the death certifical been signed by the attending phenould be detached for use as the	Physician/Med	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year	
	at the dod by the etached	hys	9 ☐ Unknown 9 ☐ Unknown			
	s that gened on de de	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death	?
3	equir en si ould		14 Dry 45 hd 1/660 gramed.	1 🗆 Yes	s 2 No 3 Probably 4 Unknown	own
	law r as be	Completed	*	24a. Was an autopsy		able
0	The The	Con		perform	ed? death? No 1 \(\text{Yes} 2 \subseteq No	OI
3	clan: clan: ertific	Be	25. Was case referred to medical examiner? 26. Place of Death			
5	hysi hysi this c	2	1 ☐ Yes 2 ☐ Abo	ne S Decider	6 ☐Other (Specify)	
9	Jing Jing J	lo	1 □Natūral 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe hov	v injury occurred	
	ttand death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined. 28e. Place of Injury - At home, farm, street, factory, office	206 Leastine (Ct.)		
observed to the second second	lor A after Dira	Certification;	4 Homicide determined determined building, etc. (Specify)	City or Town,	eet and Number or Rural Route Number, State)	
	spita lours neral		29a. Certifier 1 Certifier 1 Certifier 29a. Certifier 1 Certifier	and due to the cau	(sa/s) and manner as stated	
	te Ho 1 24 h 19 Ful	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, dat	te and place, and due to the cause(s)	
	DIVISION OF VITAL INC. To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2.	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Month, Day, Year)	
			1 Males Breegh DITT	3	7/12/0x	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0 7:20	
	\sim		31. Date filed (Month, Day, Year) 32. Registrar's Signature	me 17	1001001	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		*	

crn		For	State of Maryl					lental Hy	giene			
		State Registrar		Ce	rtificate	of Dea	th		Reg. No.	104	222	20
Physic	ian	Decedent's Name (First, Middle, Last)						Date of De Month	Day	Year	3. Time o	of Death
/Med		GARY MARSHALL FICK						July	11	2004	6:13	A M
Exami	iner	4a. Facility Name (If not institution, give s			4b. City, Tov					unty of Death		
	-	50 Jacobs Ladder (5. Social Security Number 6. Sex		lask hiddeds 3	Sevel	ma Pa	LK der 24 Hrs.			e Arun		
Funeral Director		1.50	IM 2□F	yrs. last birthday) Yrs.		ays Hour	rs Min.	8. Date of Bir (Month, Da	ıy, Year)	9. Birthi	place (State ntry)	or Foreign
		214-82-1303 Usual Residence of Decedent	43					April 2	28, 196	51 Mary	/land	
yland		10a. State 10b. County	10c	City, Town or Lo	cation					1	10d. Inside C	Dity Limits
Man	to	Maryland Anne Arun	lab.	everna I	フェアル					İ	1 🗌 Yes	s 2XXNo
h the	Director	10e. Street and Number	uci D	CVCIIIa I	10f. Zip Co	de			10g. Citizen	of What Cou	ntry?	
h wit		50 Jacobs Ladder C	ourt		2114	6			United	l State	25	
ITYIANG Z1Z15-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "neturet, or items 23a or 28e-f show imatic event, the Medical Evanil est marke redified at	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent	of Hispanic	Origin? (Spe	cify Yes or No Rican, etc.)	- 14. [Race - Americ	can Indian,	
after or Ite		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🙀 No If Yes, Give		1 ⊡Yes 2 😡			Hican, etc.)		Black, White,		
ours Liel:	d by	3 Widowed 4 Divorced	Year or Dates:			140 Spac	uy.		Spe	ecify: Whi	Lte	
21215-0036 d within 72 hours af giene. or then "neturel", or the Medical Even	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Okind of work d	one during m	nost of worki	ng	16b. Kind o	f Business/In	dustry	
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aryla should ind Men s marke umatic	2	Eugene Marshall Fi					an Ke					
0 0 0 0	M	19a. Informant's Name/Relationship (Typ. Vicki Fick - Wife	oe, Print)					Severn				211/4
m 1 an 1 an 1 an 1 an 1 an 1 an 1 an 1 a		20a. Method of Disposition	20	b. Place of Dispo			1	-				21140
Baltimore, permit. Pages 1 a Department of Hea Importent: If Item any injury or othe once.		1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crer	natory or other	place)	July		20c. Locatio	on - City or To	wn, State	
CITY transfer trent sjury		'4 □Donation 5 □Other (Specify)		len Have			200			Burnie,	_	
Gal Separ Mpool		21. Signatura Funeral Service License	°. /	K.j	.Name and Ad rkley-	dress of Fa Ruddic	cility ck Fune	eral Ho	me_P.A	. 21	.061	_
_ 40100		Jan a Coo	00							ie, Ma		
Physician /Medical	ı	23a. Part1. Enter the disease, or complice shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	e dause on each line. Cutting u Due to (or as I con.	Dound o							Approximat Interval Bet Onset and I	lween Death
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	ie ie	if any, leading to immediate cause. Enter Underlying	Due to (or as a con:	sequence of):						-		
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oa / bu, icate be executed physician and s the burial-transit	cal	d.										
tifica tig ph as th	P											
D. BOX be death certification of attending ped for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregna Other (specify					Date of delive Month	_	Year
at the de	Phy	9 Unknown						_				
ecords, relative that as been signed be 2 should be deta	by	Part II. Other significant conditions cont	tributing to death but not	resulting in the ur	nderlying cause	given in Pa	rt I.	23e. Did to	V	ontribute to th	e cause of d ably 4 □t	
fecc e law re has be je 2 sho	Completed							24a. Was		b. Were autor	osy findings	available
₽ 0 ← 0	E							autop	med? 2 \Begin{array}{c} No	death?	npletion of ca 2□ No	ause of
VICAL P	O)	25. Was case referred to medical				26. Pla	ice of Death	(Check only or		124 1 63	2 140	
90	To B	examiner? 1 XYes 2 □ No	ospital:	ER/Outpatien	3 □ DOA	0.11		ne 5 ☐ Resid		Other (Specify	at s	cene
_ = 7		27. Manner of Death	28a. Date of Injury (Month, D y Y ar	28b. Time of	28c. l	njury at Work?		8d. Describe h	ow injury occ	urred		CCITC
	ertiflcation;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	towned 7/11/00	Fouletty		1 ☐ Yes 2	ZNo (w rec	Lwite	nsaw	ana	
lor Attenuation Director:	tiflo	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, offi	се	2	8f. Location /S	treet and Nu	mber or Rural	Route Num	iber,
LIV telor A s after al Direct	Cer		Handing, etc. (ope	OMC				SEVEN	no Pru	Jacob	Shodd	uvci
To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying Physi (Check only one) 2 ☑ Medical Examine	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at th	e time, date ny opinion, d	and place, a eath occurre	nd due to the o	ause(s) and late and place	manner as sta e, and due to	ated. the cause(s))
To the within To the compl	Me	29b. Signature and title of certifier			29c. Lic	ense numbe	r	2	29o. Date sign	ned (Month, L	Day, Year)	
F->F-0		Large He	010n in 11	10		0-0	M.E.			12, 20		
21		30. Name and address of person who con	npleted cause of death (I	tem 23a) (Type	Print)	J.0			Cary	,	J-1	
00		31. Date filed (Month, Day, Year)	12 AN W 32. Registrar's Sig	d 111		treet,	Balt	imore,	Maryla	nd 212	.01	
St Regist	ate rar	JUI 1 5 2004	free free	4	100	,						

			1 - For State Registrar		laryland / De	partment ertificate			and M	F	Reg. Nø.		22221
	Physici	an	1. Decedent's Name (First, Middle, La	•						2. Date of Dea Month July	Pay	2004	3. Time of Death
	/Medic Examir	cal	Ruth Elizabe 4a. Facility Name (If not institution, giv 3261 York Str	e street and number		4b. City, T		ocation o		оиту	4c. Co	unty of Death	
			5. Social Security Number 6. S		ge (In yrs. last birthd:			If Under 2		8. Date of Birth			
	Funeral Director		215-34-1656	I M 2 🖾 F	83 Yrs	Months	Days	Hours	Min.	(Month, Day) Aug. 9	Year)	9. Binni Cou Mar	place (State or Foreign ntry) Yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Mary a-f sh	tor	Md. Carro	11	Manch	nester							1 ☐¥es 2 ☐ No
	h with the 23a or 28	ai Director	10e. Street and Number 3261 York Stree	t		10f. Zip (102			_	of What Cou	ntry?
Maryland 21215-0036	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ther than "natural", or items 23s or 28s-f show ent, I'm Medical Examinet must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No	3. Was Decede If Yes, specif		panic Orig , Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Race - Ameri Black, White, ecify: Whi	etc.
5-0	72 ho	etec	15. Decedent's E (Specify only highest gra		16a. De	cedent's Usual ive kind of work a. DO NOT use	Occupat done du	ion iring most	of workir	ng	16b. Kind o	of Business/In	dustry
121	be filed within 72 hatal Hygiene. d other then "natu	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+) life	B. DO NOT use House					Hom	nemaker	•
d 2	il Hygi other	Be Co	17. Father's Name (First, Middle, Last,)		110000		18. Mother	r's Name	(First, Middle,			
ylar		To B	Clarence E. Ha	mpshire				Ed	lna S	tuller			
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Jeanne Link -							Route Number	-		21157
	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition	MIGGE	20b. Place of Dis	sposition /Name	a of					on - City or To	
E L	Pages nent of int: If It iry or o		1 🛱 Burial 2 □ Cremation 3 □ * 4 □ Donation 5 □ Other (Specif		Trinity	rematory or oth r Cemete	ery	Ju	uly 1	.7, 2001	t 1	lanches	ter, Md.
Baltimore,	permit. Pages. Department of It Important: If Ite any Injury or ot once.		21. Signature Fuyer rvice Licer	hard	_					hardt I Manches			pel, P.A.
			23a. Part1. Enter the disease, or com shock, or hear failure. List only	plications that cause one cause on each	d the death. Do not line.	enter the mode	of dying,	such as o	ardiac or	respiratory arr	est,		Approximale Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	You west	re (Co.						viet C-1
	Examiner				s a consequence of):								
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease of Injury	Due to (or as	s a consequence of):				*******				
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):								
8760,	e be e /sician e buria	calE	l	d.									
9	ntificate ng phys as the	Medi	IF FEMALE:										
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death	3 □Ectopic preg 5 □ Other <i>(spec</i>					23d.	Date of delive Month	ery Day Year
of Vital Records, P	gned gned oe de	by	Part II. Other significant conditions of	contributing to death	but not resulting in the	underlying cau	use given	in Part I.			bacco use c		ne cause of death?
eco	aw as b	ompleted								24a. Was a		Were auto	psy findings available mpletion of cause of
E R	The ate h page	Con								perforr	ned? 20 No	death?	2□ No
Vita	Physiclan: Th this certificate ral diractor, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Other			(Check only on			
	ding Phys th. After this funeral di	n: To	27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b. Time	of 280	c. Injury a Work?	t it		e 5 Veside 8d. Describe ho			/)
sior	Attending r death. sctor: After by the fune	atio	→ Natural 5 Pending 2 Accident investigation	1	ay Year) Injur	М		s 2 🗆 N	lo				
Division	I or Attendated after death Director:	ertification	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of in	ijury - At home, farm, tc. <i>(Specily)</i>	street, factory,	office		2	Bf. Location (St. City or Town		imber or Rura	l Route Number,
	Hospita 4 hours Funeral 6ly filled	edical C	(Check only) 2 Medical Exar	niner: On the basis of	of my knowledge, de of examination and/or	ath occurred at	the time,	, date and	place, ar	nd due to the ca	ause(s) and	manner as st	ated.
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner s	tated.		License r					ned (Month, I	
	- 5 - 5				12 22			EE	161		7	15	0-1
	10		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)	- Com	مسرو ہ	P=1	a Hu	when	ten)	ar 2 3 (074)
	Sta Registr	•	31. Date filed (Month, Day, Year) JUL 1 5 2004	Sens 32. Regist	rar's Signature	ports	1			1	1		

			For State Ragistrar	State of Ma	aryland / [Departmer Certifica				Reg. Nø.) (, ;	22222
	Physicia	m	Decedent's Name (First, Midd	lle, Last)					2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		FRANCES	FAIR		1 11 00			July	11 2	1004	70/3 AM
	Examine	er	4a. Fecility Name (If not institution	on, give street and number)	+01	4b. City	, lown, or	Location of D	eath OCO	4c. County	of Death	
			5. Social Security Number	6. Sex 7. Age	e (In yrs. last bir	thday) If Unde	r 1 Year	If Under 24 I	Hrs. 8. Date of Bir	th	9. Birthpla	ce (State or Foreign
	Funeral Director		212-36-1515	1□M 20XF		Yrs. Months	Days	Hours N	fin. 8. Date of Bir (Month, Date of Line)	.6,1937	Count	SC
	ס		Usuel Residence of Decedent									
	show	_	10a. State 10b. Count	y	10c. City, Tow	n or Location					10	d. Inside City Limits 1X Yes 2 □ No
	Sa-f	ecto	MD	NIA	BALT	IMORE	. 0 - 1 -			10g. Citizen of	Albat Count	
	with the	直	10e. Street and Number			107. 21	p Code	11		US.		, y t
	eath na 23	eral	1314 W. FRANK	12. Was Decedent I	Ever in U.S.	13. Was Dece	2122		' (Specify Yes or No Jerto Rican, etc.)		e - America	n Indian,
(0	or Itama	Fun	1 Never Married 2 ☐ Ma	Armed Forces?					uerto Rican, etc.)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ck, White, e	tc.
93	72 hours after death with the Maryland hatural; or Itama 23a or 28a-f show dical Examinet must be nutified at	by	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give Year or Dates:		1 Yes	2 K I No	Specify:		Specify	BLAC	CK
5-0	72 h natu	Completed by Funeral Director	15. Decede (Specify only high	nt's Education est grade completed)	16a	Decedent's Usu (Give kind of w	ork done o	during most of	working	16b. Kind of B	usiness/Indi	ıstry
121	l within iene. r than	dω	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT		"		EMTE:	Dጥ ለ ፕእኩ	√ENTT
7	be filed within 72 hours after death with the Manylan Ital Hygiene. Ind other than "natural", or Itama 23a or 28a-f show evant, Ira Medical Examiner must be mitthed at	ပိ	12 17. Father's Name (First, Middle	Last)		BARTEND	EK	18. Mother's	Name (First, Middle		RTAIN 18)	1EN I
an	Mental Mental arked o	To Be		NK				G	ENEVA FAI	R		
Marvland 21215-0036	s 1 and 2 should be f Health and Mental itam 27 is marked othar traumatic ev	-	19a. Informant's Name/Relation	ship (Type, Print)	198	. Mailing Addres	s (Street a	and Number of	Rural Route Numb	er, City or Town,	State, Zip	Code)
Ž	and 2 lealth a m 27 is		BRENDA GILES/	NIECE	3	3700 GRE	ENSP	RING AV	ENUE BAL	TIMORE,	MARY	LAND 21211
ore.	es 1 ar of Hea f itam r otha		20a. Method of Disposition	3 □Removal from State	20b. Place o cemete	f Disposition (Na ry, crematory or	me of other plac		Date	20c. Location	City or Tov	m, State
<u>Ĕ</u>	Pages ment of ant; If it, ury or o		'4 Donation 5 Other (MT.	2101			19/64	Balt	00	ND
Baltimore.	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service	s G. Wort	in					MORTON IMORE,		F.H., INC.
	PA ELS		23a. Part. Enter the disease, of shock, or heart failure. Lis	or complications that caused st only one cluse on each lin	the death. Do	not enter the mo	de of dyin	g, such as care	diac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acut	e Gas	triat	ect	nal	Hemor	chas		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	,		121.63	()	
- 1		-	Sequentially list conditions,	b. Due to for as	a consequience	oft:					-	
15	nslt	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~								
, G	be executed siclan and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence	of):						
8760	te be ysicla	Ical		d								
9	leath certifica attending ph d for use as th	Med	IF FEMALE:									
Вох	ath ce itendi	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal death						te of deliver	V Day Year
Ö	the a	/slcl	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death	5 Other (s	pecify)					,
الم م	that the di ed by the detached		Part II. Other significant condit	tions contributing to death b	ut not resulting i	n the underlying	cause giv	en in Part I.	23e. Did t	tobacco use cont	ribute to the	cause of death?
\mathcal{NC} ecords.	v requires that been signed should be de	d b	End Stas	e liver s	Disec	ure			1 🗆	Yes 2□No	3 🗆 Proba	bly 4 Onknown
200	w requ	lete	3						24a. Was	an 24b.	Were autop	sy findings available
Re	iclan: The lar certificate has rector, page 2	Completed by							— auto perfo 1 ☐ Yes	psy ormed2 2 X No	prior to com death? N 1 Yes 2	sy findings available pletion of cause of
Z Iz		ø	25. Was case referred to medic	al				26. Place of	Death (Check only of	-7	100 .	A
7 2	y s	To B	examinar? Yes 2 No	Hospital: 1Inpatie	ent 2DER/O	utpatient 3 D	OA Oth	er: 4 🗆 Nursin	g Home 5 Resi	dence 6 □Oth	er (Specify)	
70	ng Phys fter this neral di		27. Manner of Death 1 XNatural 5 ☐ Pend	28a. Date of Injur (Month, Day	ry 28b.	Time of Injury	28c. Injun Worl		28d. Describe	how injury occur	red	
Sio	eath. or: A	catle		tigation		М		Yes 2 □ No	1001			
Fail	or Att	Certification:		mined 28e. Place of Inju- building, etc	ury - At home, fa c. <i>(Specify)</i>	arm, street, facto	ry, office		City or To	Street and Numb wn, State)	er or Hurai	Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a, Certifier Certify	ing Physician: To the best	of my knowleda	e, death occurred	d at the tin	ne, date and pl	ace, and due to the	cause(s) and ma	inner as sta	ted.
	e Hos 24 h e Fun letely	Medical		al Exeminer: On the basis of and manner sta	examination ar							
	To th within To th compl	Me	29b. Signature and title of certifi	ier		29	c. Licens	e number		29d. Date signe	d (Month, D	ay, Year)
			Jun E	men	0		7) 5) R. F (Ye	CIND	111	MCGS
_	5		30. Name and address of perso						2 11	1		1
			31. Date filed (Month, Day, Yea		ar's Signature	iton P	wer	me,	Baltin	026 1	May	yland
	Sta Registra		JUL 1 5		ar's Signature	4 In	m de	7				
			AUL I D	4004	./~	1400	- work					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year John E. Feiler 2004 6:40 P M Ju₁y 10 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar. 29, 1 **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days Hours Min. 88 Yrs. Director 212-05-2617 1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 28e-f show 10d. Inside City Limits other traumatic evant, the Medical Examiner must be notified at Director MD N/A Baltimore TV☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 927 DeSoto Road 21223 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: White 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. othar than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Shipping Calvert Distillery Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be pe John Feiler Mary Guenther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If itam 27 Is,
any injury or other trau,
once. Linda Feiler Daughter-in-law 1036 Parksley Ave., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State MD or tex errains or Change the ry 4 ☐ Ponation 5 ☐ Other (Specify) @ Crownsville 7-16-2004 Crownsville, MD Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 2122/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final congestive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cardiomyopat

Due to (or as a consequence d): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide

Division of Vital Records, P.O. Box 68760

Diractor:

Certification:

within 24 hours a To tha Funarai

State

Registrar

DHMH 17 Rev 1/2001

Medical

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Tsc M Richer Hospita 838 N 2. Registlar's Signature

Entaw St Balfinere, MD 21201

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24170

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

(so M)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5			For State Registrar	State of M	aryland		artment rtificate			nd Ment	al Hy	/giene Reg. No.	004	2	2224
	D		1. Decedent's Name (First, Middle, L	_							ate of De	eath Day	Yea		Time of Death
	Physici /Medic		Charles	Henry For	ns					Jı	ıly :	12, 20	04		2205 p ^M
	Examin		4a. Facility Name (If not institution, gi				, ,		Location of	Death			ounty of D		
			Saint Joseph Me			ast birthday)	If Under	OWSC	If Under 2	4 Hrs lon	ate of Bi		Baltir		(Cto to Fi
	Funeral Director		5. Social Security Number 6. 064-16-6044	Sex 7. Ag 1 X M 2 □ F	83	Yrs.		Days	Hours		rch	1619	21	Vew Y	(State or Foreign
			Usual Residence of Decedent												
	show		10a. State 10b. County			, Town or Lo									nside City Limits
	e Ma	cto	Md. Balti	more	Bal.	timore	·								□Yes 2XNo
	th with the Ma 23s or 28s-f	ai Dire	10e. Street and Number 8820 Walther	Blvd. #452	5		10f. Zip (234				10g. Citize	n of What		
21215-0036	after des or Items	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 \(\mathbb{X} \) es 2 \(\text{If Yes, Give} \) Year or Dates:	?		Was Decede If Yes, speci 1 Yes 2		panic Origi , Mexican, Specify:	in? (Specify \ Puerto Rican	es or No , etc.)			merican Ind thite, etc. Whi	
5-0	72 ho	eted	15. Decedent's f	Education rade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupat k done du	tion uring most	of working		16b. Kind	of Busine	ss/Industry	,
2	nthin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or	5+)		<i>po nor use</i> nistra					US G	overr	nment	
	iled v Hygie ther t nt, in		17. Father's Name (First, Middle, Las			, talli i	113014		18. Mother	's Name (Firs	t. Middle				
Maryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", ' raumatic event, I're Medical Exa	To Be	Charles Form	S		1			Loui	se Sc	heze	er			
	and 2 sh ealth and n 27 ls m		19a. Informant's Name/Relationship Mrs. Margaret Fo							#4525					
Baitimore,	Pages 1 and the properties of		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Spec		се	ace of Dispo metery, crer 1top S	natory or oth	he <i>r pla</i> ce		Date 2-17-04			tion - City on, N	or Town, S	itate
Baiti	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Firmeral Service Lice		1111					uneral Towso			204	10.	
			23a. Part1. Enter the disease, or col	mplications that cause	d the death									Appr	roximate
	Physician		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Head		chest	inhir	Les						Onse	val Between et and Death
	/Medical Examiner			Due to (or as	a consequ	ence of):	O								
	uted d ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):									
8760,	sate be executed thysician and the burial-transit	ai Exa	resulting in death) Last	Due to (or as	a consequ	ence of):									
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S, P	uires that the d signed by the d be detached	by	Part II. Dther significant conditions	contributing to death b	out not resu	Iting in the u	nderlying ca	use giver	n in Part I.	2	3e. Did 1	_			se of death?
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Vital	Physician: this certific ral director,	To B	examiner?	Hospital:	ent 21/27 8	ER/Outpatien	it 3□ DO/	Other	-	sing Home			Other (Si	pecify)	
l of	g Phy er this		27. Manner of Death	28a. Date of Inju	ırv	28b. Time of		Bc. Injury Work				how injury o	ccurred	1 .0	0
io	Attending I r death. ector: Atter by the funer	atio	1 □ Natural 5 □ Pending 2 → Accident investigati	on July 12, 20		Foundary 11:00	A ^M		es 2 📉 N	o Pass	enger	in mo	ter un	ude	id-
Division	or Atterder de Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine	a 286. Place of In	jury - At hor tc. (Specify,	me, farm, str	eet, factory,	office		C	ity or To	Street and N wn, State)			
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Ext	Physician: To the best aminer: On the basis of and manner st	of examinati		vestigation,	in my opi	nion, death			date and pla	ace, and d	lue to the c	
	To t To t	Σ	29b. Signature and title of certifier	1	1 1 10	`		License ME	number			29d. Date s July	-		(ear)
	VI		Jasha g	heerberg	ACD										
	10x,		30. Name and address of person who TaSha Z. Green	berg M.D.	Death (Item	∠3a) (Type,	11:	1 Per	nn St	reet,	Balt	imore	Mar	yland	21201
	Sta	-	31. Date filed (Month, Day, Year)		rar's Signat		1								
	Registr	ar	JUL 1 5 2004	1 Denne	4	D y	Spark	201							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY Day Year 13, 2004 **Physician** 1:59A Magdalene Fischer Agnes /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center OWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 04/25/1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 213 12 6626 6. Sex **Funeral** Months Days Hours 1 M 2 X Director Usual Residence of Decedent the Maryland 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examinational be notified at Rosedale MD Baltimore 1 Yes 200 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21237 8300 Philadelphia Road USA or items 23a death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 0 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John L. Schafer Helen Klein 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traur Martin J. Fischer Sr. SON 1514 Cedar Wood Drive Bel Air Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Nation 3 ☐ Removal from State St. Joseph Fullerton 07/16/04 *4 □ Donation 5 □ Other (Specify) Fullerton, Maryland 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician LONG ABDOMINAL ADRIIC ANEURYSM /Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to for as a consequence of: Examiner burial-transit and certificate be execu Due to (or as a consequence of): attending physician for use as the buria of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a, Was an autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🕱 No 1 X Inpatient 2 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After t Certification: Division 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) D 54274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 SOLEDY SAMER 14 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

IUL 1 5 2004

)44	188		1 - For State Registrar AMEND III		Marylan	•				and M	ental Hy	giene Reg. No:()	2001	. 200	226
	Physici		Decedent's Name (First, Middle Mark Leonard G	, Last)			<u> </u>				2. Date of Do Month	Day	Yea 104	ar 122	of Death)
ı	/Medic Examin		4a. Facility Name (If not institution 2901 Childs		nber)			, Town, or Balti	Location of	of Death	uury_		County of D	eath) a
	Funeral Director		5. Social Security Number 432–35–5688	6. Sex 1√GM 2□ F	7. Age (In yrs. 43	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da Jan. 2	rth a <i>y</i> , <i>Year)</i> 1, 196	9. i	Birthplace (State Country) ittle Rock	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside 0	City Limits
	e Man le-f sh lifte J	ctor	MO B	arry				Monet	ct					½ √Yes	2 □ No
	th with th	al Director	10e. Street and Number 114A Aubree Co	ırt			10f. Z	ip Code	65708			10g. Citiz	en of What USA	: Country?	
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id elygiene. Id other than "natural", or itams 23a or 28e-f show other than "natural", or itams 23a or 28e-f show event. I'm Modinal Exam har must be molified at	by Funeral	11. Marital Status 1 Never Married XX Marr 3 Widowed 4 Divorced	Armed Fo	2 /2 /No			edent of Hi ecify Cuba 2000	ispanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)			merican Indian, /hite, etc. white	
2-0	72 ho "natur	eted	15. Decedent (Specify only highes	's Education at grade completed)		16a. Dece (Give	kind of v		during mos	t of worki	ng	16b. Kin	d of Busine	ss/Industry	
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and 2	should be filed withir na Mental Hygiene. marked other than metic event, III.M.	Be	17. Father's Name (First, Middle, Joe Gould								(First, Middle			A HENTHO	DNE
Maryland 2121	S a a	2	19a. Informant's Name/Relations. Gina Bowman Gould				-		and Numbe	er or Rura	I Route Numb	er, City or			MUS
altimore, I			20a. Method of Disposition 1 □ Burial 2 □ Cremation		01-1- 6	Place of Disponentery, crementery, tory of	other plac	ily 13,		Pate	20c. Loc		or Town, State		
Baltin	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (S		P. Doda	<u></u>	arles	L. St		Funer	al Home,		~		
ı			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.	th. Do not ent	er the m	ode of dyin	g, such as	cardiac o			<u>su</u>	Approxima Interval Be Onset and	tween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseq	Ry Aquence of):	RT	ery	THI	Rom	BUSIS				
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rds, P.O	luires that the signed by	by	Part II. Other significent condition	ons contributing to de	eath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did		_	e to the cause of	
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	er		(Check only				
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Division of	f or Attanding after death. Director: Afte I in by the fune	Certification;	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At h ng, etc. (Special	ome, farm, str fy)						(Street and wn, State)	Number or	Rural Route Nur	nber,
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	To the Howithin 24 To the For	Med	29b. Signature and title of certific		in		2	9c. License					_	onth, Day, Year)	
	10		30. Name and address of person	who completed caus	e of death (Iter	m 23a) (Type,	Print)				h n-14		-		1201
	Y Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa	ature	,		enn S	cree	ı, Ball	LUIIOI	e, Mai	ryland 2	1201
	Regist		JUL 1 5 2004	Deney	ye /	T A	oour	2							

Thomas Edward) E	ilbert Unpend item	se Type or-	Printi	n Black in	delible	lnk Z	, Ensu	ге . ДІ	l Copies	Are Leg	gible.	
cm		1 - For State Registrar MEND IT	Se Type 07- State of #5.8.16	Mary	land / Depa Oa-c Ce	rtificati	t of F e of	lealth a Death	nd IV		giene Beg. No.2	01.	22227
	#: 2	1. Decedent's Name (First, Middl		,						2. Date of De.	ath	Va.	3. Time of Death
Physici /Medic		Thomas Edwa	rd Gilbert							Month June	Day 27	2004	6:35 A ^M
Examin		4a. Facility Name (If not institution	n, give street and nun	nber)	-	4b. City,	Town, o	or Location o	f Death		4c. Coun	ity of Death	-U-U
(J-	April 1	28 E. Mt. Ven				1 If Under		timore			9/2/19	948 N/A	
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fand wo		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or Lo	cation						100	d. Inside City Limits
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i6 after dea or Items	nue	11. Marital Status	12. Was Dece Armed For	ces?	in U.S. 13.	Was Deced	dent of H	lispanic Orig an, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra	ace - American lack, White, et	
36 rs afte	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Vac Can		6-68	1 ☐ Yes 2	2 X No	Specify:			Spec	ity: whit	:e
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arylan, should be ind Mental	F	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address	(Street	and Number	r or Rura	l Route Numbe	er, City or Tow	n, State, Zip C	'ode)
and 2 and 2 eath a m 27 ts		John Magnotta/	half broth	er	2028	S. Ph	hili	p Stre	eet 1	Philade	lphia,	PA 191	48
Baltimore, Moemit. Pages 1 and 2 Beatiment of Health Deptement of them 1 my injury or other tre once.		20a. Method of Disposition	2.55		Ob. Place of Dispo	sition (Nan	ne of			ate		· City or Tow	
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*, % ,	ĺ	23a. Part Enter the disease, or shock or heart failure. List	only one cause on ea	ich mie.		er the mode	e of dyin	ng, such as o	cardiac d	r respiratory ar	rest,	Ír	approximate nterval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, or Attending Physicien: The law requires that the death certificate be executed after death. In the certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outd			Ectopic pre	egnancy	,				ate of delivery	
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Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 ☐ Cartifyir (Check only one) 2 ☑ Medical	g Physician: To the Examiner: On the ba and mann	sis of exar	knowledge, death nination and/or inv	occurred a	at the tin in my o	ne, date and pinion, death	l place, a h occurre	and due to the o	ause(s) and mate	anner as state , and due to th	ed. e cause(s)
o the ithin o the	Me	29b. Signature and title of certifie				29c.	. Licens	e number		2	29d. Date signe	ed (Month, Da	y, Year)
FSFO		Joshe?	Thee h	The Co				O.C.	M.E.		June 27	, 2004	
		30. Name and address of person		of death	(Item 23a) (Type,	Print)							
1		Tasha Z Gira		.D			n St	reet.	Bal	timore,	Marvla	and 212	201
Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's S	ignature								
Registr	ar	JUL	1 3 2004	pale	أثرر سنابالأ	Jan Salar	W.	,					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ALEXIS GRANT 0624 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore City UNIVERSITY OF MUTRICHANDIMEDICAL SYSTEM BALTIMORE, MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. J. Worth, Day Year 58 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Fermsylvania **Funeral** 216-78-0507 1 ☐ M 2 🗓 F 45 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Example in must be notified at City Baltimore Md. 1X☐Yes 2☐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1046 Rockhill Rd. 21229 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural, or Iten any injury or other traumatic event, the Mudical Exam. ance. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Md. Dept. Nat. Resource 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Alexander Grant Camille Khalil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Camille K. Grant - Mother 1317 Harden Lane, Pikesville, Md. 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State St. George Cemetery July 20, 2004 Bridgeville, Pa. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21. Signature of 21117 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bets Immediate Cause (Final disease or condition resulting in death) Physician LIVER CIRRHOSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) the attending physician the dor use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No မ 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rente P17624 7/14/04 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA UNIVERSITY OF MARYLAND MEDICAL SYSTEM, BALTIMORE, MD 21230 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:00 A M **Physician** 2001 Jul Livia A. Giangrandi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE STAGNES HEALTHCARE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 🖾 F 213-10-7999 Yrs. 93 June 4, 1911 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than *naturel', or itema 23e or 28e-f show any injury or other traumatic event, if a Medical Exercities must be rediffed at once. 1 ☐ Yes 2 ☑ No Directo Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9525 Longview Drive 21042 U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Papagno Maria Cinquina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) B. Robert Giangrandi (Son) 2886 Rosemar Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash. Crematory 7-11-2004 Laurel, Maryland 21. Signature of Funeral Service Licensee Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition INFARCTION MYCCARDIAL DAYS Physician resulting in death) /Medical Examiner Securentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 DEctopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To ō 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury Division 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1/0023580 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. 3449 WILKENS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2004 Registrar

DHMH 17 Rev 1/2001

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			for State Registrar	State of Ma	aryland		artment of I rtificate of		and Mental Hyg	giene neg. Nø.	22230
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an	ld be ental ked c	To Be	Isaac Moffitt:	i Brown				Mau	die Elizabe	th Brown	
Maryland	shoul nd M	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Numbe	er or Rural Route Numbe	r, City or Town, State, .	Zip Code)
	nd 2 salth ar		Geraldean R. Wai	lker / Daug	ghter	3818	Rock Run	n Road	, Havre de (Grace, MD 2	21078
Baltimore,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene after 23 is marked other than "natural", or items 23s or 28s-1 show then traumatic avent. Ite Medical Exercities must be notified at		20a. Method of Disposition	_	20b. Pla	ce of Dispo	sition (Name of matory or other pla	ice)	Date	20c. Location - City or	Town, State
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s,	es De de	þ	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause gi	ven in Parti		bacco use contribute to	. •
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	o the Horithin 24 orthe Fu	Medicai	29b. Signature and title of certifier	5/ 10.	7		29cg. Licen	se number		9d. Date signed (Mont	h, Day, Year)
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Donna Holmes 04-04572 MAN unpend item#23a,PArt II,27,28a-f,PER ME,G833,7/27/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	/Medi Examii	cal	Jonna 4a. Facility Name (If not institution, give	Street and number	or)	FIUINIE		Town, or	Location of	of Death	July		. County of Deat	1318 P M
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97	Funeral Director		5. Social Security N 213 - 86 - 0	683 15	X JM 200 F	Age (In yrs	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of R (Month, Nov. 3	Birth Day, Year)	Co	nplace (State or Foreign untry), Yland
	land ow] }	Usual Residence o 10a. State	10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
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	or 28a-f	Director	10e. Street and Nu		a i			10f. Zip						tizen of What Co	untry?
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other treumetic event, If a M. ADRE.	To Be Co	17. Father's Name	(First, Middle, Last)	olmas		7,000	,		18. Mothe	er's Name	(First, Midd Edw	lle, Maiden ardS	Sumame)	
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Division	or Attendi after death. Director: A in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of building, found at	njury - At h etc. (Speci	lome, farm, str fy)	eet, factory,				City or T	nun State	1	ral Route Number, timore, MD
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical Ce	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	sician: To the be:	st of my kn	owledge, deatl	n occurred a	at the time	e, date and inion, deat	d place,	and due to th	e cause(s)	and manner as	stated.
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Phyelcien: The law requires that the death certificate be executed within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use es the bune-trensit	Box 68760,	eath certificete be executed	Мika		
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			1. Decedent's Name (First, Midd	le, Last)					2. Dete of D		14	3- Time 61-Dealth
	Physicia		Howard B.	Heald					JULY	12, 20	Year)04	6:10pm
}	/Medic Examin		4a. Facility Name (If not institution	n, give street end n		***		4b. City, Town	, or Location of Dea		of Death	
			Oak Crest Vill	age 8820	Walther	Blvd.			ville	Ba1	timor	e
	Funeral Director		5. Social Security Number 488-28-6841	6. Sex 1 X M 2 □ F		s. lest birthday) 79 Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D OCT • 2	irth lev, Year) 26, 1924		ace (State or Foreign ry) SOULI
Ţ	2 2		Usual Residence of Decedent 10a. State 10b. County	,	100.0	ity, Town or Lo	cation				10	d. Inside City Limits
char	ehov ed et	5		ltimore	100.0	nty, rown or Lo					10	1 ☐ Yes 2 Ž No
tho A	28a-1	Directo	10e. Street end Number	TUMOLE			Parkvill	Le		10a. Citizen of V	Vhat Count	rv?
ž.	Sa or	ā		D1J			2123	34		USA		.,.
400	13 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral	8820 Walther 11. Marital Status	12. Was De	cedent Ever in	U,S. 13. V	Vas Decedent of F	lispanic Origin	? (Specify Yes or N	o- 14. Rac	e - America	
Sale of	perim. Figor 1 size 3 should be seen way and periment of the state of the seen with the way and important: If them 27 is marked other then "netural; or items 23s or 28s-f ehow any injury or other traumatic event, the Medical Evantiner must be notified at once.	by Fur	1 Never Married 2 Mar 3 Widowed 4 Divorce	If Yes (2 □ No Sive		r Yes, specify Cubi	an, Mexican, F Specify:	Puerto Rican, etc.)	Specify	ck, White, e	nc. Thite
2	etura		15. Deceder	nt's Education		16a. Deced	ent's Usuel Occup	ation	formal fam.	16b. Kind of Business/Industry		
. i	Wed.	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	1) (1-4or 5+)		kind of work done OO NOT use retired	during most o d)	f working	Heating and		
1	/gienr	5	12			M∈	echanic			Air Conditioning		
9 9	d oth	Be	17. Father's Name (First, Middle,						Name (First, Middle		ie)	
pluc	d Mer narke	Howard W. Heald Jo Jo Information Name/Palatingship (Type Print) 10b Mailing Address (Street and Number)					sephine B		Cto to Tio	Codel		
0	thand 7 Is n		19a. Informant's Name/Relationship (Type, Print) Doris S. Heald/wife 19b. Mailing Address (Street and Number or Ru 8820 Walther Blvd. P						Parkvill			C00e)
5 5	Heal Heal tem 2 other	Doris S. Heald/Wife 20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Metro Crematory, Inc.						Date			vn, State	
9	y or							7/13/04				
į	oortar / Injur		21. Signature of Funeral Service		20011	22	. Name and Addre	ss of Facility	1	1		
8	25.58		Davas	McDonald	MYWW				ty of Mar oad Balt			20
			23a. Part1. Enter the disease, o shock, or heart failure. Lis		caused the dee	eth. Do not ente	er the mode of dyir	ng, such as ca	rdiac or respiretory e	errest,	1 .	Approximate Interval Between
•	hysician											Onset and Death
	/Medical xaminer		Immediate Ceuse (Final disease or condition resulting in death)	a C	ongest	rive (teart	Fai	JULE			2 yrs
		er	•		Due to	(or es a conseq	uence of):					
4	d ensit	Examiner	Conventiolly list conditions	6. [-)	Due to	or as a consequ	neuce of).)	305
icate he evenited	physiclen end the buriel-trensit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ulmor			- Len	sion		1	0 415
of of	ysicl he bu	edical	Cause (Disease or injury thet initieted events resulting in death) Last	c	Due to (or as e consequ						
Supplied		/Mec		d. C	hron	ic 01	55 truc	tive	Pulnu	mars	Dise a	se loyer
£ 6	d for u	Physician/M	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the un	iderlying cause giv	ren in Part I	23b. Did	tobacco use con	tribute to	the cause of death?
9	by the	hys								Yes 2□No		ably 4 Unknown
, 4	pe de	ρ	Abdomina	Mart	7 (/	Hreuri	45~					
Attending Physician: The law requires that the death certification	should be deteched for use es	Completed	Abdomind Benisn Pr	rostate	1447	ser tro	phy		24a. Wes	s an autopsy ormed?	avei	e eutopsy findings lable prior to pletion of cause eeth?
- 4E	te hec	E							10	Yes 25 No	1 🗆	Yes 2□ No
6	rtifice stor, p	Be C	25. Was case referred to medica examiner?	ı				26. Place of	Death (Check only	one)		
Java	nis ce	인	1 Yes 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpetient		4 LI Nuisi	ng Home 5 Resi			
0	After th	on:	27. Manner of Deeth 1 Natural 5 □ Pendi	ng (Mo	e of Injury nth, Dey Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆			how injury occurr	ed	
T C	death tor: /	icat	2 Accident invest 3 Suicide 6 Could	not be	e of Injury - At h	nome farm stre	eet, factory, office	Yes 2 □ No		Street and Number	er or Rurel	Route Number
1	effer Direc	Certification:	4 ☐ Homicide determ	build build	ding, etc. (Spec	ify)	set, lactory, cilico		City or To	wn, State)	51 G7 7161 G7	Toute Trained,
alla	hours nerel y fille		29a. Certifier 1 Certifyi	ng Physician: To th	e best of my kn	owledge, death	occurred at the tin	ne, date end p	place, and due to the	ceuse(s) and ma	nner as sta	ted.
H H	within 24 hours effer death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as s of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.										
Ę	Tol	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							.1			
	1	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)							17			
	V		WILLIAM M.	Russell	8800	WALTH	Print)	PA	ARWILLE	MD 2	123	ч
	Stat Registra											

Physician /Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

Medical Certification; To Be Completed by Physician/Medical Examiner

For State Registrar		(Certificate of D	ealth and N Death		1. No.)	20020
. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	CORR	3. Time of Death
	Willia	am Joh:	-		JULY	12 2004	1800
a. Facility Name (If not institution,		I THAN DE	4b. City, Town, or L	0	0	4c. County of Deet	
. , , , , , , , , , , , , , , , , , , ,	TAL OF BAI	e (In yrs. last birth	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	/ A thplace (State or Foreign
220-05-2932	1 M 2 □ F		Yrs. Months Days	Hours Min.	JUL 24	rear) Co	inplace (State of Forei Juntry) Maryland
Isual Residence of Decedent		10c. City, Town	* ***		001	1/1/	
0a. State 10b. County	Harford	10c. City, 10mi.		deen			10d. Inside City Limit 1 ☐ Yes 2 XN
0e. Street and Number	larrora		10f. Zip Code	ueen	100	. Citizen of What Co	
1519 Ernest	Lane		101. 202	21001	-	USA	Junuy :
Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of Hisp If Yes, specify Cuban,		pecify Yes or No-	14. Race - Ame	
1 Never Married 2 Married	d 1 ☐ Yes 2 人 1 N If Yes, Give		1 ☐ Yes 2 🌠 No	Specify:) Hican, etc.,	Black, White	e, etc.
3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a I	Decedent's Usual Occupati		16	W	hite Madustay
(Specify only highest	grade completed)		Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)	iring most of work	ang	b. Kind of Business/	/Industry
Elementary/Secondary (0-12)	College (1-4or 5)+)	Laborer			Construc	ction _
7. Father's Name (First, Middle, La	-				ne (First, Middle, Ma		
Richard	Hopkins		-	Mary		Howlett	-
19a. Informant's Name/Relationship Roberta R. Wall			Mailing Address (Street an			-	
Roberta R. Wel	LSN, GLanuud	20b. Place of D	Disposition (Name of			ark, MD 2	21550 Town, State
1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	cemetery,	Crematory or other place)	nc. 07/1	4/04	Baltimo	
21. Signatulo 1 Funoral Service Lic	11/00/1/1	2_	Cremation	of Solitziet	ty of MD	, Inc.	
George E. 23a. Part1. Enter the disease, or co	MacNabb omplications that caused	the death. Do no	299 Frede				MD 21228 Approximate
shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lin	ne.		SUCII de our	Or respiratory and	'	Interval Between
disease or condition	UKV	EUMON	A				Onset and Death
resulting in death)		a consequence of					2 clays
resulting in death)					_		Onset and Death Zalays
Sequentially list conditions, and leading to mmediate	Due to (or as a		f):				Onset and Death Zays
resulting in death) Sequentially list conditions,	b. Oue to (or as a c.	a consequence of	ŋ: Ŋ				Onset and Death Z clays
Sequentially list conditions, tary, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events	b. Oue to (or as a c.	a consequence of	ŋ: Ŋ				Onset and Death 2 clauss
Sequentially list conditions, tary, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events	b. Oue to (or as a c.	a consequence of	ŋ: Ŋ				Onset and Death Z clays
Sequentially list conditions, tary, leading to immediate sause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	b. Due to (or as a d. 23c. If yes, outcome	a consequence of a consequence of of pregnancy	f): (f):			23d. Date of deli	Zdays
Sequentially list conditions. I any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a b. C. Due to (or as a d. 23c. If yes, outcome 1 Live birth	a consequence of a consequence of a consequence of of pregnancy 2 \(\begin{array}{c} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ŋ: Ŋ			23d. Date of deli	Zdays
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown	Due to (or as a d. 23c. If yes, outcome 1 \(\triangle \text{ birth} \) 4 \(\triangle \text{ Pregnant at } \) 9 \(\text{ Unknown} \)	a consequence of a consequence of a consequence of of pregnancy 2 Fetal death time of death	3 Ectopic pregnancy 5 Other (specify)			Month	Z clays
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F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a b. Due to (or as a d. Due to (or as	a consequence of a consequence of a consequence of a consequence of 2 Fetal death time of death ut not resulting in the consequence of a consequence of pregnancy 2 Fetal death time of death at a consequence of the conseque	3 Ectopic pregnancy 5 Other (specify) the underlying cause given A Fib, P Mo Si S patient 3 DOA Other.	26. Place of Death	1 Yes 24a. Was an autopsy performe 1 Yes 2 An Check on one	Month 200 use contribute to 2 No 3 Pro 24b. Were au prior to c death? No 1 Yes	ivery Day Year the cause of death? obably 4 Unknow ttopsy findings available completion of cause of
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions: 1 Yes 2 No 9 Unknown 2art II. Other significant conditions: 25. Was case referred to medical examiner? 1 Yes 2 No 9 Was decedent pregnant in the past 12 months? 25. Was case referred to medical examiner? 26. Was case referred to medical examiner? 27. Manner of Death 28. Matural 5 Pending investigated in the past 12 months?	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as	a consequence of a consequence of a consequence of a consequence of 2 Fetal death time of death ut not resulting in the consequence of a consequence of pregnancy 2 Fetal death time of death at a consequence of the conseque	3 Ectopic pregnancy 5 Other (specify) the underlying cause given A A P No Si S patient 3 DOA Other. The of 28c. Injury a Work?	26. Place of Deatl 4 Nursing Ho	24a. Was an autopsy performe 1 Yes 2 th Check on one ome 5 Residence 28d. Describe how	Month 2 No 3 Pro 24b. Were au prior to c death? No 1 Yes 6 6 Other (Specinjury occurred	ivery Day Year the cause of death? obably 4 □Unknow ttopsy findings available completion of cause of
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State Registrar

JUL 1 5 2004 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	tate of Maryla		artment of H		_	giene		22234			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Janelle Beth Heitko					2. Date of De Month July 9	Day 20	04	2:45 am M			
	Examin	er	4a. Facility Name (If not institution, give stre Montgomery General 5. Social Security Number 6. Sex	Hospital	s. last birthday)	(Clney If Under 24 Hrs.	8. Date of Bi	Мс	County of Dea	ry			
	Funeral Director		214-74-7243 Usual Residence of Decedent	2 X F	50 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Mar 3,	195	4 Vi	rthplace (State or Foreign Country) rginia			
	ne Marylan 8a-f show cullied at	ector	MD Montgomer		City, Town or Lo	9			10 00	izen of What O	10d. Inside City Limits 1 □ Yes 2 No			
	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 14106 Canterbury La 11. Marital Status 12.	Was Decedent Ever in	U.S. 13.	10f. Zip Code 20853 Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	Uni	ted Sta	ates erican Indian,			
	ours after o rrel', or Iter	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)	Specify: White					
12131	within 72 h ene. then "netu	Completed	15. Decedent's Educat (Specify only highest grade co			during most of work	g most of working		b. Kind of Business/Industry /A					
מווא	uld ba filed fental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Robert Herman Heitkotter				18. Mother's Name Zelma El	•		*				
, Mai y	and 2 shousalth and Market nation 27 is mailer traumater	-	19a. Informant's Name/Relationship (<i>Type</i> , Deanna Beal/Sister	·	4151	Nora Dri	and Number or Run ve, Finks	burg, N	4D 21	048				
	Pages 1 tment of He tant: If iter		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	Oval IIOIII State	hesapea	osition (Name of matory or other place ake Cremat	tory	Date Jul 15 2004		cation · City o				
Da	Depar Impor any ir		21. Signature of Funeral Services Licensee	ture MOD ions that caused the de	382	933 Gist	eral & Cre Ave. Sil	lver Sp	ring		Approximate			
	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ADULT Due to or as a cons	equence of):		1 SYNO	RMF			Interval Between Onset and Death			
	Examiner	iner	Sequentially list conditions, if any, leading to innecdate cause. Enter Underlying	Due to (ur as a surie	MON!	4					INC			
,00,	cate be executed physician and the burial-transit	ical Examin	Cause (Disease or injury that initiated events c. = resulting in death) Last	Due to (or as a cons	equence of):									
O. DOY O	To the Hospital or Attending Physicien: The law requiras that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	⊒Ectopic pregnancy ⊒ Other (specify) _	,		1	23d. Date of do Month	elivery Day Year			
ords, r.	quiras that t n signed by uld be detac	by	Part II. Other significant conditions contribute of the significant conditions	outing to death but not r	resulting in the u	inderlying cause giv	en in Part I.	23e. Did	•	1	to the cause of death? Probably 4 □Unknown			
חבבים	sicien: The law rescriticate has bee lirector, page 2 sho	completed	Downs sy	in Drong				24a. Was auto perfe 1 \sum Yes		prior to death?	autopsy findings available completion of cause of			
1 V 11 a	Physicien: The this certificate har director, page	To Be C	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Ye} \)	pital: 1 patient 2	☐ ER/Outpatie	nt 3□ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			6 □Other (Sp	ecify)			
	tending Pt Jeath, tor: After th the funeral	ertification:	27. Manner of Death 1 Maturat 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year,		M 1	yat k? Yes 2⊡No	28d. Describe						
2	pital or At burs after d erel Direct filled in by	O	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)		me date and place	City or To	wn, State)	Rural Route Number,			
	To the Hospital or within 24 hours aft to the Funerel Discompletely filled in	Medical	(Check only one) 2 Medical Examine 29b. Signature and title of certifier	On the basis of exam and manner stated.	ination and/or in	29c. Licens	pinion, death occur e number	red at the time.	date and	te signed (Mor	ie to the cause(s) oth, Day, Year)			
	V		30. Name an admiss of person who comp	pleted cause of death (I	tem 23a) (Type	Print) S	DSWILL	67	00	2/9	1200 4			
		ate	31. Date filed (Month, Day, Year)	OKOJ/ 32. Registrar's Sig		513 NEW	Hompsite	NF AVE	TAW	ma PARU	c up 20915			

& Sparis

State

Registrar

		4	for State Registrar	State of M	-	epartment of Certificate				iene og. Ng2 () () ()	22235
	Physicia /Medic		1. Decedent's Name (First, Middle, La	son Helms				J	Date of Dear	th Day Year 13, 2004	3. Time of Death 11: 50 P M
	Examin	or	4a. Facility Name (If not institution, giv BALTIMIZE REHADILIT	ATION EXTER	DED CAR	ē		LTIM	ORE	4c. County of Deat Baltimor	re
i,	Funeral Director		5. Social Security Number 250–46–6474 Usual Residence of Decedent	Sex 7. A	ge (In yrs. last birti 70 Y	Months Da	ear If Under	Min.	Date of Birth (Month, Day May 21	Year) 1934 Nor	hplace (State or Foreign unity) rth Carolina
	Maryland	tor	10a. State 10b. County Md. Baltim	ore	10c. City, Town	or Location ndallstow	n				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a set be not	ai Director	10e. Street and Number 3202 Elmo Dr	ive		10f. Zip Co	21133		1	U.S.A.	· ·
980	within 72 hours after death with the Maryland ene. than "natural", or tlems 23e or 28e-f show the Madical Exeminer must be mullisd at	by Funeral	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 XYes 2 If Yes, Give Year or Dates:	? 1958-	13. Was Decedent If Yes, specify 1 ☐ Yes 2 ☑	Cuban, Mexica	n, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	be filed within 72 hours tal Hygiene. d other than "natural", event, the Medical Exe	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)			Decedent's Usual O (Give kind of work d life. DO NOT use n Exray Te	one during mo: atired)	st of working		6b. Kind of Business/Industry Veterans Hospital	
/land		To Be C	17. Father's Name (First, Middle, Last Clayton P.				18. Mother's Name (First, Middle, Mar Eva Surratt			Maiden Sumame)	
	s 1 and 2 should I Health and Men Item 27 is marke other treumstic		19a. Informant's Name/Relationship (Type, Print) Joe C. Helms, Jr Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 3202 Elmo Drive, Randallstown, Md. 21133								
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	(y)	cemeter	o Crematory or other	ry (July 1	7, 200	4 Baltimore	
Bal	permit. Pag Department Important: any injury o		21. Signature of Association Service Lice 23a. Part1. Enter the disease, or con-	Quadf	d the death. Do		Reister	rstown	Rd.,	Owings Mill	Ls, Md. 2111 Approximate
	Physician /Medical Examiner		23a. Part : Enter the disease, or con- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CANCE	line.	LUNGU	1 4	1 1		est,	Interval Between Onsel and Death
	ocuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events	c	s a consequence o		-				
8760,	cate be executed physicien and the burial-transit	dical	resulting in death) Last	Due to (or a	s a consequence o	·f):					
.O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		e of pregnancy 2 Petal death at time of death	3 □Ectopic pregr 5 □ Other (specif				23d. Date of del Month	ivery Day Year
0	quires that n signed b uld be deta		Part II. Other significant conditions LIVER METI	contributing to death	but not resulting in	the underlying caus	e given in Part	1.		bacco use contribute to es 2⊡No 3 ⊠ Pr	the cause of death?
of Vital Records		Completed by	CORONARY AR	TERY DI	SEASE				24a. Was a autops perform	an 24b. Were au prior to o death? 2 No 1 □ Yes	atopsy findings available completion of cause of
Vita	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Hospital:	-5.500	-C.no.	Other		Check only or		
	g Physier this	n; To	1 Yes 2 No 27. Manner of Death	28a. Date of In	jury 28b. T	ime of 28c.	Injury at Work?	-		ence 6 Other (Specow injury occurred	сігу)
1 Natural 2 Accident 3 Suicide 4 Homicide 4 Ho						М	1 Yes 2	-	f. Location (S. City or Tow	treet and Number or Ru n, State)	ıral Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	of examination and	, death occurred at t d/or investigation, in	he time, date a my opinion, de	nd place, an ath occurred	d due to the c at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	Tang	be. D.	D	cense number	-8	V	29d. Date signed (Monte)	h, Day, Year)
_	1		AUFORA C. T	AN 390	U LOCH	PAVEN BUI	ILEVA	RD, B,	ALTI KU	IRE, MD:	2/2/8
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 5 2004	32. Regis	trar's Signature	Sports	/				

	ŧ			artment of Health and Mental Hygiene ertificate of Death Reg. No. 1 11 22236
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medic		Louie Leong Hing	July 14 2004 9:10 a M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 1506 Bedworth Road	4b. City, Town, or Location of Death Time prices
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Timonium Baltimore Hunder 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign)
	Funeral Director		217-32-5565 1⊠ M 2□F 71 Yrs.	Months Days Hours Min. FeD 15, 1933 Children
	D		Usuel Residence of Decedent	
	anylar show	r	10a. State 10b. County 10c. City, Town or I Md. Baltimore Timoni	
	the M	Director	10e. Street and Number	
	death with the Maryland rms 23a or 28a-f show rmust Le notified at		1506 Bedworth Road	10f. Zip Code 10g. Citizen of What Country?
	death	Funeral		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
٥	after or Ite		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ Mo If Yes, Give	
2-0036	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-f show sufficial Examiliar must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:	open, Milite
ဂ်	in 72 "nat	Completed	(Specify only highest grade completed) (Giv	ident's Usual Occupation a kind of work done during most of working DO NOT use retired) 16b. Kind of Business/Industry
7 7	filed within 72 Hygiene. other than "nat	mo	Elementary/Secondary (U-12) College (1-4or 5+)	Chef Restaurant
<u> </u>	be filed tal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
ylan	Men Men arke	To	Louie You	Yip Chun Hung
ă	12 h a ris			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>ရ</u>	s 1 and f Health item 27 other to		20a Method of Disposition 20b. Place of Disp	5 Bedworth Rd. Timonium, Md. 21093 osition (Name of Date 20c. Location - City or Town, State
Ē	Pages nent of int: If it iry or o		1 Labural 2 Li Cremation 3 Li Hemoval from State	Park Cem. 7-17-04 Woodlawn, Md.
galti	permit. Pages Department of Important: If i any injury or once.			2. Note of the follows of Facility of Home, Inc.
מ	88 E 8			1050 York Rd. Towson, Md. 21204
			23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
ا	Physician		Immediate Cause (Final disease or condition resulting in death)	erct dementia "Onset and Death Months
	/Medical Examiner		Due to (or as a consequence of):	6 100 000 111
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	7 mons
	outed nd ransit	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events c. Hypertens	100 GOANS
Š.	e exection articles	Ex	resulting in death) Last Due to (or as a consequence of):	0 000
0/0 0/0	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	dlcal	d	
o XO	rding rding rse as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	23d Data of delivery
2	death a atter d for u	clar	in the past 12 months? 1	□Ectopic pregnancy 23d. Date of delivery □ Cther (specify) Month Day Year
j.	by the	hys	9 □ Unknown	
'n	The law requires that ate has been signed b page 2 should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	
cords	requir	eted		es 2 No 3 Probably 4 Unknown
ည	2 8 8	Completed		24a. Was an autopsy autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
	rsician: The law s certificate has b lirector, page 2 s	င္ပ	25. Was case referred to medical	1 ☐ Yes 2 ☐ Mo 1 ☐ Yes 2 ☐ Mo
5	ysicia s cert directo	0 B	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only one) 10ther: 4 □ Nursing Home Statement 6 □Other (Specify)
5	ng Ph ter thi	T; T	27. Manner of Death 28a. Date of Injury 28b. Time	A Description
IVISION	tendir eath. or: Af the fur	catlo	2 Accident investigation	M 1 Yes 2 No
Ž	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	spital ours a neral I		29a. Certifler 1/2 Scertifying Physician: To the best of my knowledge dea	h occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Madical Examiner: On the basis of examination and/or in one)	evestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	vithir To th	×	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	11) / m	USS14 - 1/14/04
	6		Name and address of person who completed cause of death (Item 23a) (Type VALL N. +05/5/2, MD 6565 N. (1	PARCES ST #203 BACT MD R1204
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	land 1

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** July 2004 11:10 AM 10 Beatrice Hahn /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 412 Irene Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 28, 1916 Birthplece (State or Foreign Country)
 VA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2₽F 219-16-1743 87 Yrs. Director Usual Residence of Decedent s t and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic avent, the Medical Examinar must be nutified at 1 Yes 2 No Director Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A. 412 Irene Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify. 3XXWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Beautician Hair Salon permit. Pages t and 2 should be file Department of Heatth and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic avent, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Thomas Frazier Bessie Lee Seal ٩ 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Beatrice L. Crouse 600 Carrack Drive, Saint Marys, GA 31558 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Park Jul 14,2004 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral Home P.A. 11936 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of). the attending physicien Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Year 5 Other (specify) detached this certificate has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by page 2 should be 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 10 or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the f within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide Hospitel 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y. Markan 305 Holpital Dr. 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For Amend Item 1,24a per Dr., G33,07/15/04dhb 1- Registrar Certificate of Death		_	20000
					No. UU4	22238
	Physicia		1. Decedent's Name (First, Middle, Last) Mae K. Johnson	2. Date of Death Month	Day Yeer	3. Time of Death
5	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	6	4c. County of Dear	
	Examin	er	10411 A SQUEL St. 7 " Floor Baltonore	>	N	7a
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs., last birthday) If Under 1 Year If Under 24 Hrs.	8. Dale of Birth (Month, Day, Ye	9. Bin	hplace (Stete or Foreign
U	Director		740-38-777 10 M 2/2 74 Yrs. Months Days Hours Min.	11/15/	29	1.C
	pu 🔉		Usuel Residence of Decedent 10a. State 10b. County 10c_City, Town or Location	1.70		10d. Inside City Limits
	shore and	ō	MD Na Faltanoro Cit	/		1 Yes 2 □ No
	the A	Director	10e. Street and Number / 5 2 10f. Zip Code	10g.	Citizen of What Co	juptry?
	Mith Mith		10411/14 isquite St 217.07		1) 96	7
	filed within 72 hours after death with the Maryland Hygiene. kher than "natural", or Items 23e or 28e-f show kher than "natural", or Items 23e or 28e-f show bnt, the Medical Examination	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No-	14. Race - Ame Black, Whit	
ထ	or ite		1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:	riican, etc./	Specify: 5	Plan /
1215-0036	ural',	d by	3 Widowed 4 ADiverced Year or Dates:		2	year \
V	natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) [life. DO NOT use retired]	ing 16b	. Kind of Business	Industry
12	withir ene. then	E C	Elementary/Secondary (0-12) College (1-4or 5+) ORIGINAL AND AND AND AND AND AND AND AND AND AND		NURSING	
9	filed with Hygiene. other the	ပိ	The abilities of	e (First, Middle, Mai		
<u>a</u>	should be nd Mental marked o	To Be	TIPN LUISS RESSIE	Copy Ion	d.	
Maryland 21	& DEE		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rura	al Route Number, Ci	ty or Town, State,	Zip Code)
Σ	and 2 Baith a n 27 ls			HMERE, MD		
ore	of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)		. Location - City or	
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Baltimore,	permit. Pag Department Important: any injury c		1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility BE	HS KINERIL.	Home	
	20 = a d		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	sultimers	10 2121	3 Approximate
	,		shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Interval Between Onset and Death
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146 167		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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Вох	ath ce Itendi	an/	23b. Was decedent pregnant 1		23d. Date of de Month	livery Day Year
	the al	sici	1 Yes 2 No 9 Unknown 9 Unknown			ŕ
P. 0.	that the ed by detac	Phy	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did Iobac	co use contribute l	o the cause of death?
ds,	signé d be	d by	Hoportens; on	1 ☐ Yes	2 No 3 P	robably 4 Unknown
į	w requ	Completed		24a. Was an	24b. Were a	utopsy findings available
Re	he lav e has	шć		autopsy performer 1 ☐ Yes 2 ☐	prior to	completion of cause of
ta	sicien: The law requires that the death certificate be excentificate has been signed by the attending physician rector, page 2 should be detached for use as the buria	O	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2 € h (Check only one)	1 101	20110
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the tuneral director, page 2 should be detached for use as the	To B	examiner? \ c \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ome 5 Residence	e 6 Other (Spe	ocify)
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Ö	endir sath. or: Af he tur	atic	2/Accident investigation M 1 Yes 2 No			
Ž	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S		ural Route Number,
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the tuner	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only and manner stated) Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date	and place, and du	o stated. o to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier 29c. License number	1 / 29d.	Date signed Mon	th, Day, Year)
	F 3 F 8		1 A LA MINI TORKH	45	A617	9/2004
1	14		30. Name and address of person who completed cause of death (I)em 23a9 (Type, Print)		1010	1100-1
(7		315 11, Calvert with Floor Fration	more,	11/61	
4	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		V	
	Regist	rar	111 0 1 2001 hours & Sparker			
DH	fMH 17 Rev 1/2	001	JOF A 1 5004			

		1 - State Ragistrer AMEND ITEM	State of Maryla 19b PER FH C	nd / Depa 837 약	artment of h ####################################	lealth and M Death	Re	eg. No. [] []	22239
Physici /Medic Examin	cal	4a. Facility Name (If not institution, give s				or Location of Death	2. Date of Deat Month July 11	Day Y 2004 4c. County of	
uneral irector		Greater Baltimore 5. Social Security Number 128-14-4276 Usual Residence of Decedent	7. Age (In yrs	last birthday)	Towsor If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 2,	Year) 9	timore Birthplace (State or Foreig Country) New York
r 28a-f show notified at	Director	10a. State 10b. County MD Baltimo		Timoni			10	0g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Comportances of reseat and western riggenes. Important: If time 27 is marked other than "natural", or teams 23a or 28a-f show any injury or other traumatic svant, If a Marked Examination as 200.000.	by Funeral DI	119 Hollow Brook R 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Road 12. Was Decedent Ever in 1 Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 43 *—		Was Decedent of H	.093 Hispanic Origin? (Span, Mexican, Puerto Specify:		USA 14. Race - Black,	
yelene. har than "natura t, ire Modical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired Manager	during most of work	ing I	16b. Kind of Busin Detinning Ianufactu	g Metal
s marked oth	To Be	17. Father's Name (First, Middle, Last) Frank Henry Johnso 19a. Informant's Name/Relationship (Type)		19b. Mailir	ng Address (Street	18. Mother's Nam Dagmar and Number or Rui	ue (First, Middle, M Ueland ral Route Number,		ate, Zip Code)
int: If itam 27 iny or other tra	1000	Doris Johnson/Wife 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b	Place of Dispo	ollow Bro esition (Name of majory of other place Valley L Gardens		15,	MD 210 20c. Location - Cit	y or Town, State
Importa any inju		21. Signature of Funeral Privio Lines e	chael J. Fla	gle 10^{22}	Name and Address mmon Fun W. Pado	ss of Facility eral Home nia Road	of Dula Timoniu	ney Vall m, MD 21	ey, Inc. 093
edical aminer	Examiner	23a. Parl. Efter the disease, or complic shock, or fleart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the first or figure.	Due to (or as a conse	quenco):	failur		or respiratory arre	st,	Approximate Interval Between Onset and Death
tending physician and r use as the burial-transit	cal	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a conse	nancy	Dectopic pregnancy	,		23d. Date of	
been signed by the attending ph should be detached for use as th	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	4□Pregnant at time of 9□ Unknown	death 5	Other (specify)		23e Did tob	Month	Day Year
been signe should be	leted by						1 ☐ Yes	s 2 No 3	Probably 4 Unknown
After this certificate has funeral director, page 2.	Be Completed	25. Was case referred to medical examiner?		98		26. Place of Deat	autopsy perform	ed? prior deat	
ector: After this ce	Certification: To	1 Yes 2 No Hi 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h	28b. Time of Injury	28c. injun Wor M 1	er: 4 □ Nursing Ho y at k? Yes 2 □ No	28d. Describe how 28f. Location (Stre	w injury occurred	Specify) or Rural Route Number,
To the Funeral Director: After completely filled in by the funer	edical Cert	29a. Certifier 1 Certifying Phys	building, etc. (Specifician: To the best of my knier: On the basis of examin	owledge, death	n occurred at the tin	ne, date and place,	City or Town, and due to the car red at the time, da	use(s) and manne	or as stated.
To tha	Med	29b. Signature and title of certifier	Handly A	70	29c. Licens		29	d. Date signed (M	
1 1	te	30. Name and address of person who con Alexa F. Faraday, 31. Date filed (Month, Day, Year)		N. Char		et, Suite	5103 Bal	Lto., MD	21204

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

eath (Item 23a) (Type, Print)

6701

32. Registrar's Signature

St. Balto . md

			1 - For Amend Item 26	State of Maryland				Mental Hygi	ene g. No? () () [22241
	Physici /Medic		Decedent's Name (First, Middle, Last) Lawrence A	Kopp		Ab City Town o	r Location of Death	2. Date of Death Month July 12	Day Year	3. Time of Death 10:45 a ^M
,	Examin	er		venue	and brings of and	Baltimore If Under 1 Year	e County	8. Date of Birth	Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 213 48 0118 1 G	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	(Month, Day,	7 1947 Bal	thplace (State or Foreign buntry) timore, Maryland
	death with the Maryland ms 23a or 28a-f show	tor	10a. State 10b. County Maryland Baltimore		, Town or Lo	cation 2 County				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3a or 28a 1 be not	i Director	10e. Street and Number 5511 McCormick Av	enue		10f. Zip Code 21206		10	og. Citizen of What Co USA	ountry?
	within 72 hours after death with the Marylan iene. Ithan "natural", or items 23a or 28a-f show Ithe Maulical Examination must be notified at	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
	within 72 hou ene. than "natura he Mudicul E	Completed I	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Business	
N	be filed tal Hyg d other evant,	Be	12 17. Father's Name (First, Middle, Last) Tilden Jordan Kopp	Ŋ̈́A	Owner		18. Mother's Nan	ne (First, Middle, M	Ied's Towing Maiden Sumame)	
Maryland	and and	2	19a. Informant's Name/Relationship (Typ Susan G Kopp	e, Print)		ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
altimore, I	Pages 1 and 2 nent of Health int: If item 27 I iry or other tre		20a. Method of Disposition 1 Magurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	lace of Dispo emetery, crea	esition (Name of matory or other place) Faith Cen.	ce)	Date 2	20c. Location - City or Baltimore, Ma	
Baltin	permit. Pag Department Important: b any injury o		21. Signature of Funeral Service License		25	Name and Addre	ss of Facility		e,Maryland	
60,	Medical Examiner Medical Exami	cai Examiner	23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or important initiated events resulting in death) Last	Due to (or as a conseq	uence of):	ter the mode of dyin	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death 8 Months
P.O. Box 687	To the Hospital or Attanding Phyalcian: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregns 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date of de Month	livery Day Year
ds, P.	uires that the signed by detacted		Part II. Other significant conditions con-	tributing to death but not res	ulting in the u	underlying cause gr	ven in Part I.		eacco use contribute t	o the cause of death?
Division of Vital Records,	The law requite has been bage 2 shoul	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
Vital	slcian: certifica rector, j	Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Ot		th (Check only on	e) ance 6 Other (Spe	acifu)
on of	To the Hospital or Attanding Phyalcian: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju Wo	ry at		ow injury occurred	ony)
Divisi	al or Attar s after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knoner: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the vithin To the	Me	29b. Signature and title of certifier	MS		29c. Licen	5780Z	2:	9d. Date signed (Mon	th, Dey, Year)
•	20		30. Name and address of person who co	3.45				house M	layland 2	1231
	St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sign		1	, ,			

DHMH 17 Rev 1/2001

JUL 1 5 2004

mor & sports

Disconti		1 - For Unpend Item #23a, 27, Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of De	eath	3. Time of Death
Physic /Med		JAMIE	ERIN	KAUFMAN	ZÜÜL Y	10 ^{Pay} 2004	
Exami	ner	4a. Facility Name (If not institution, give street and number 12007 TARRAGON ROAD APT	^{er)} • A	4b. City, Town, or Location of Dea REISTERSTOWN	th	4c. County o BALT 1	
Funeral Director		352-66-4148 1□M 2万F	Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Bir (Month, Da DEC.	2, 1978	9. Birthplace (State or Foreign Country)
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	peation			10d. Inside City Limits
ne Mar 8a-f st otiffed	Director	MD BALTIMORE	REIS	TERSTOWN			1 ☐ Yes 2 🕅 No
with to	I Dire	10e. Street and Number 12007 TARRAGON ROAD APT	. A	10f. Zip Code 21136		10g. Citizen of WI	nat Country? USA
r death	Funeral	11 Marital Status 12. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hispanic Origin? (() If Yes, specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 14. Race Black	- American Indian, White, etc.
urs afte	by Fu	1 X Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	XI No	1 ☐ Yes 2 🂢 No Specify:		Specify:	WHITE
72 hou nature		15. Decedent's Education (Specify only highest grade completed)	/Give	dent's Usual Occupation kind of work done during most of wo	rking	16b. Kind of Bus	iness/Industry
Description of the property of the process of the p	Completed	Elementary/Secondary (0-12) College (1-4	life.	DO NOT use retired)	·	FINANC	E
12 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. 7 is marked other than "naturel", or Items 23s or 28s-f show reumatic event, the Medical Examinal must be notified at	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle	, Maiden Sumame)
d Menid harke	10	DENNIS A. 19a. Informant's Name/Relationship (Type, Print)	KAUF	MAN LINDA ng Address (Street and Number or R	ural Pouto Mumb	nor City or Tourn S	LESK
ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumatic		LINDA LEVIN / MOTHER		7 TARRAGON ROAD,			
ges 1 and 2 it of Health If item 27		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	(0	matory or other place)	Date	20c. Location - C	
permit. Pag Department Importent: I eny injury o		`4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	HILLTOP	SERVICE CORP 7/15 2. Name and Address of Facility SC			SON, MD
permit. Departn Importe eny inju		Rocet / Tum		900 REISTERSTOWN			
		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ı line.		c or respiratory a	irrest,	Approximate Interval Between Onset and Death
Pnysician /Medical		resulting in death)	pine intoxi as a consequence of):	cation			
Examiner							
uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
ate be executed hysician and the burial-transit	Еха	that initfated events resulting in death) Last c. Due to (or	as a consequence of):				
icate b physic s the bi	dica	d					
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcor		□Ectopic pregnancy		23d. Date	
he dea r the att	ysici		at time of death 5	Other (specify)		Monti	n Day Year
s that t	by Ph	Part II. Other significant conditions contributing to death	n but not resulting in the u	nderlying cause given in Part I.	23e. Did t	tobacco use contrib	ute to the cause of death?
require een sig nould b					1 🗆	Yes 2□No 3	Probably 4 Unknown
The law cate has b	Completed				24a. Was auto	psy pri- prmed? de	ere autopsy findings available or to completion of cause of ath?
(0	Be Co	25. Was case referred to medical examiner?		26. Place of De	ath (Check only o		ves 2□ No
Physicien: this certific ral director,	²	1 X Yes 2 No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of It			1	dence 6XOther	(Specify) AT SCENE
nding ath. r: After	ation	1 Natural 5 Pending Found 7/10/0	Day Year) FOUND	aM 28c. Injury at Work? 1 □ Yes 2√ No	Unkno		
or Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Certification:	4 ☐ Homicide Set Could not be determined 28e. Place of building,	Injury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (City or To	Street and 2007 wn, State 2007	Tarragon Road
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific		29a. Certifier 1 Certifying Physician: To the be	in residenc st of my knowledge, deat	n occurred at the time, date and place	and due to the	stown, MD	ner as stated
the Ho nin 24 h the Fu npletely	fedical	one) 2M Medical Examiner: On the basis	s of examination and/or in	vestigation, in my opinion, death occi	irred at the time,	date and place, an	d due to the cause(s)
	Σ	29b. Signature and title of certifier	u mid	29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) 11, 2004
To Vor		30. Name and address of person who completed cause of	f death (Itgm 23a) (Type,	Print)			
1 / x		31. Date filed (Month, Day, Year) 32. Regi	strar's Signature.	enn Street, Balti	more, Ma	aryland 2	1201
St				paly			

		•	State of Maryland 1 - State Registrar AMEND ITEM #11PER FH G833		artment of Health and N	lental Hygie	0001	22210
	Physici /Medic		Decedent's Name (First, Middle, Last) HELEN		KLASSON	2. Date of Death Month JULY 11	Day 2004 Year	3: Time of Death 1:25 P M
	Examir		4a. Facility Name (If not institution, give street and number) ATRIUM ASSISTED LIVING		4b. City, Town, or Location of Death OWINGS MILLS		4c. County of Death	
	Funeral Director		5. Social Security Number 056-05-7252 Usual Residence of Decedent	ast birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye JAN.31,1	9. Birthp Cour	lace (State or Foreign stry) NY
	anyland ehow	ž	10a. State 10b. County 10c. City	, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-f	recto	MD BALTIMORE 10e. Street and Number	OMING	GS MILLS 10f. Zip Code	10g.	Citizen of What Cour	
	th with	ai D	4730 ATRIUM COURT #471		21117			USA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "natural", or items 23a or 28a-f ehow other treumatic event, the Medical Examinational Landilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 4 Divorced 12. Was Decedent Ever in U.: Armed Forces? 11. Was Decedent Ever in U.: Armed Forces? 12. Was Decedent Ever in U.: Armed Forces? 12. Was Decedent Ever in U.: Armed Forces? 13. Was Decedent Ever in U.: Armed Forces? 14. Was Decedent Ever in U.: Armed Forces? 15. Was Decedent Ever in U.: Armed Forces? 16. Was Decedent Ever in U.: Armed Forces?	I	Nas Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
2-00	72 hour	sted t	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business/In	
121215-0036	filed within Hygiene. other than other.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. E	CAL CLERK	N/	SSAU COUN	TY GOVT.
Maryland	should be find Mental H markad ott markad ott	To Be	17. Father's Name (First, Middle, Last) BENJAMIN	TURE	TSKY SARAH	e (First, Middle, Maid		KEER
Mai	1 and 2 sho Health and tam 27 is ma		19a. Informant's Name/Relationship (Type, Print) LISA KLASSON SHUBOW / DAUGHTER		ig Address (Street and Number or Rur GH PASTURE COURT •		ty or Town, State, Zip NILLS, MD	
ore,	8 = 5		1 A Burial 2 Cremation 3 Removal from State	emetery, cren	natory`or other place)	Date 200	. Location - City or To	
Baltimore	nit. Pa partmen ortant: injury		*4 □ Donation 5 □ Other (Specify) NEW 21. Signature of Funeral Service Licensee		EFIORE CEM. 7/14, Name and Address of Facility SOI		INELAWN, I	
Ba	Depar Impo any ir		Robert Jamo		900 REISTERSTOWN			
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final		er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a consequence of the condition of the co	RSH lence of):	566515			1 month
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequ	ience of):				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disase or Injury that initiated events	erice ory.				
8760,	cate be executed physician and the burial-transit	ai Ex	resulting in death) Last Due to (or as a consequ	ence of):				
9	tificate ng phys as the	fedicai	d.					
.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	ompleted by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 15 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 [Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
<u>α</u>	quires that t n signed by uld be deta	ed by Ph	Part II. Other significant conditions contributing to death but not resu	Iting in the ur	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Records,	× QS	omplet				24a. Was an autopsy performed	24b. Were autoprior to condeath?	csy findings available appletion of cause of
Vital	Physician: The la this certificate har ral director, page 2	BeC	25. Was case referred to medical examiner? Hospital: Hospital:		Other	(Check only one)		ASSISTED
of	ding Phys I. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of Injury	1 3L DOA 4L Nursing Ho	me 5 Residence 28d. Describe how in	6 XiOther (Specify	LIVING
Division	Attanding r death. ector: After y the fune	catio	2 Accident investigation		M 1 Yes 2 No			
Divi	al or Al	Certification:	4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify	ne, farm, stre	eet, factory, office	281. Location (Street City or Town, St	and Number or Rura ate)	Houte Number,
	To tha Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, I	
	1-		30. Name and address of person who completed cause of death (Item	23a) (Type. 1	Print)	3	Jy 12, 2	004
	V		Jef Zibell MD Suite 200 ?	25 M	ain St. Reisterst	own MD	21136	
		State Registrar JUL 1 5 2004 32. Registrar's Signature						

		1. Decedent's Name (First, Middle,					2. Date of De Month		Va	3. Time of Dea
Physicia /Medica		ADDIE	KEYS				JULY	Day	Year Zoo4	1:19 8
Examine		4a. Facility Name (If not institution,				or Location of Dea			nty of Death	
		Dorth	EST to	SPITAL		la11stowi		Ba1	timore	
uneral irector		5. Social Security Number 052-22-2140 Usual Residence of Decedent		ge (<i>In yrs. last birthda</i> 78 Yrs.	y) If Under 1 Year Months Days			1925	9. Birthpla Countr Kenti	ace (State or For ry) ucky
* =		10a. State 10b. County		10c. City, Town or	Location				10	d. Inside City Li
Ba-f sh	ector		N/A		Baltimore	9				1 X Yes 2 □
23a or 2	Funeral Director	7408 Fairbrook	Rd., 2A		10f. Zip Code	21244		US.	of What Countr	r y ?
lems Left Si	ner	11. Marital Status	12. Was Decedent Armed Foress d 1 Tyes 24	Ever in U.S. 13	Was Decedent of H	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No orto Rican, etc.))- 14. R	ace - America lack, White, et	
Exactly	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 24⊒ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣 No				cify: Blad	
dical	Completed by	15. Decedent's (Specify only highest		16a. Dec	edent's Usual Occup ve kind of work done	pation during most of w	orkina	16b. Kind of	Business/Indu	ıstry
nen W.W.	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	re kind of work done DO NOT use retire Sales	ed)	g	Dont	. Store	_
Part (ខ	11. Father's Name (First, Middle, La	act)		pares	19 Mothoda Na	ame (First, Middle,			=
arked of	To Be	Fred	Archey			Elei	nora Arc	hey		
n 27 Is rr ar traum		19a. Informant's Name/Relationship Darnetta Heath			iling Address (Street Ayrdale					Code)
Department of Health and Mental Hygiene. Important: If itam 27 Is marked othar than "natural", or Items 23a or 28a-f show eny injury or othar traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1			position (Name of ematory or other plane) Memorial		Date /12/04	20c. Location Mary1	n - City or Tow and	n, State
Importar eny inju		21. Signature of Funeral Service Lie	censee		22. Name and Addre	ess of Facility	ome, 4600	В	altoN	MD 2120
edical	Ж	Willie E. Howell Per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARD IAC ARREST Due to (or as a consequence of): CORONARY ARTERY							(Onset and Dear
aminer	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (cr as	RONAR	ARREY ART	ERY	Dise	ASE		Onset and Deat
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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No. 2 1 1 2 2 2 1 5
	Physician /Medical	$\mathbf{E} = \mathbf{F}(\mathbf{H}) \mathbf{H} \mathbf{H} \mathbf{H}$	2. Date of Death Month Day Year July 12 2004 9:15 Arm
	Examiner	An Chy Tourist Name // and institution aire street and numbers	wn, or Location of Death 4c. County of Death Bastimore
(b	Funeral Director	5. Social Security Number 6. Sex 1 M 2X F 84 1 M 0 Months Control of the security Number 84 1 M 0 Months Control of the security Number 1 Months Control of the sec	24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) SC SC
	uylend thow	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	28a-1s	MD NA Baltimore	X-X es 2 □ No
	with t	10e. Street and Number 10f. Zip Code 21207	10g. Citizen of What Country? U • S • A •
20	within 72 hours aftar death with the Maryland ena. than "natural, or items 23a or 28a-f show he Medical Examiner must be notified at amplianted by Filineral Director.		gin? (Specify Yes or No-), Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
9	"natural", or dical Exa.	31_3Vidowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	Black 16b. Kind of Business/Industry
21215-0020	filed within 72 hours e Hygiena. ther than "natural; o mit, the Medical Exa-	(Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade na (Give kind of work done during most life. DO NOT use retired) Homemaker	t of working House
nd	be filed tal Hygie d other event, the		or's Name (First, Middle, Maiden Sumame)
Maryland	Men Men	Melvin Fuller Quee	en White er or Rurel Route Number, City or Town, State, Zip Code)
	nd 2 shouth and 27 is me		ve, Baltimore, Md 21207
Baltimore,	os 1 and of Haalth I item 27 r other tr	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Ē	Pages ment of ant: If ite ury or o	4 Donation 5 Other (Specify) Druid Ridge Cemeter	y 7/17/04 Pikesville, Md
Ball	permit. Pages 1 and Department of Haalth Important: If item 27 any injury or other ti once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facilit March F/H Wes	у
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or respiratory arrest, Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) ATHERUSCIEROTIC CER	CEBRO VASCULAR DISEASE
	sit sit		
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68760,	rificate be executed of physician and as the bunal-trensit	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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	at the death ce d by the ettendi atached for use Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
°, P.O	ras that the death certifigned by the ettending be datached for use a by Physician/M	HUPERTENSION	1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown
of Vital Records,	been should	ISCHARMIC CARDIOMYDPATHY	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
= E	The law sete hes pege 2	DIABETES MELLITUS	1 Yes 2 No
Vita	cartificete ractor, peg	25. Was case referred to medical examiner?	of Death (Check only one)
	Physic rthis ca aral dire	1 inpatient 2 EH/Outpatient 3 DOA 40-10	rsing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
ion	Attending Physician: or death. ector: After this cartific by the funeral diractor, iffication: To Be (1.☑Naturel 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ I	No
Division	P# 5 = 1	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and content of the conte	I place, and due to the cause(s) and manner as stated. h occurred at the time, date and place, and due to the cause(s)
	Within To the comple		29d. Date signed (Month, Day, Year)
	1.1	Jasuen Jalmani 128595	7/12/04
-		30: Name and address of person who completed cause of deeth (Item 23e) (Type, Print) TASWEEM (AKHAN), 7220 ARK HEICHT	3 AVE, BALTO MD HER
	State	31. Date filed (Month, Pay, Year) 32. Registrar's Signature	, , , , , , , , , , , , , , , , , , , ,

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			1 - For State Registrar	Otate of Ivio	-		tificate of			Reg. No	1. 22016					
			Decedent's Name (First, Middle, Last)			-			2. Date of De	ath **	3. Time of Death					
	Physici /Medic		CHARLES R. LIGHT,	SR.					JULY 9,	, 2004 Y	5:50 P M					
	Examin		4a. Facility Name (If not institution, give s		777			r Location of Death	1	4c. County of						
			GENESIS ELDERCARE 5. Social Security Number 6. Sex		LK (In yrs. last bin	thday)	ANNAPOLI	. S If Under 24 Hrs.	8. Date of Birt	ANNE AI	Birthplace (State or Foreign					
	Funeral Director			M 2□F	= 0	Yrs.	Months Days	Hours Min.	JAN T	7, Year 1931 W	VEST VIRGINIA					
	p ,		Usual Residence of Decedent		10- Cit. T	1 .										
	faryla star	ō	10a. State 10b. County MARYLAND ANNE ARUNI)EI	10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2 No					
	28e-1	Director	10e. Street and Number	760	GLEN DO	JIXIV.	10f. Zip Code			10g. Citizen of Wha	at Country?					
	h with	i D	1313 CORY DRIVE				21061			UNITED ST	•					
	ams	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Race - Black.	American Indian, White, etc.					
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give	KOREAN		1 ☐ Yes 2 No	Specify:	·	Consider	WHITE					
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28e-f show int, the Madical Examinar must be notified at	edt	15. Decedent's Education 16a Decedent's Usual Occupation							16b. Kind of Busin						
215	hin 72 9. Medi	plet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+)													
2	ed wit ygiene yer tha t, the	Completed	12 ELECTRICIAN								ANUFACTURING					
and	be fill ad off	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, A													
Ĕ	hould d Mer marke	P	ROY W. LIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, or Rural R													
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-1 show amportent: If item 27 is marked other than "natural; or items 23a or 28e-1 show amply injury or other traumatic evant, the Medical Examination at the political at Once.		JENNIFER P. FRANKS					COVE LA	NE OUEE		TOWN, MD 21658					
Baltimore,	es 1 a of Hea litem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	amount from Chata	20b. Place of cemeter	Dispo	sition (Name of natory or other place	:в) ј ј	Date ULY 12 2004	20c. Location - Cit	y or Town, State					
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3alt	ermit. Separt nport ny inj		21. Signature of Funa al Service License	е ,		Ķ.	. Name and Addre	ss of Facility DDICK FU	NERAL HO	OME, P.A. I BURNIE,						
	007 e 0	4 3	22a Part Enter the disease or compli	nations that sauced	the death. Do s	4	21 CRAIN	HWY., S.	E., GLEN	BURNIE,	MD 21061 Approximate					
		25 i	shock, or heart failure. List only on Immediate Cause (Final	he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate to tailure. List only one cause on each line. (Final a							Interval Between Onset and Death					
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89	The law requires that the death certificate ate has been signed by the atlending physpage 2 should be detached for use as the	edic														
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Re	The la	Completed			perfo	autopsy prior to completion of death? 1 Yes 2 No 1 Yes 2 No										
/ita	cien: ertifica ector,	Be C	25. Was case referred to medical examiner?					26. Place of Death (Check only one)								
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o	Attanding Physicien: r death. ector: After this certifics by the funeral director. i	tlon	1 □ Pending 2 □ Accident investigation	(Month, Day		njury	Wor	k? Yes 2 ∐No	280. Describe i	low injury occurred						
Division of Vital Records,	Attan r deal ector by the	iflca	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, fa	rm, str	eet, factory, office		28f. Location (S	Street and Number of	or Rural Route Number,					
ā	tel or A	Certification:	4 Homicae	City or Tow	m, state)											
	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only 2 Medical Exemin	ner: On the basis of	examination and	death	occurred at the tin	ne, date and place pinion, death occu	and due to the orred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)					
	To the He within 24 To the Fu	Med	one) 29b. Signature and title of certifier	and manner sta			29c, Licens	e number		29d. Date signed (A	Month, Day, Year)					
)	\$ 1 k 3		1 /2 / Xnx	mu			D.	37036		7/10/1	n V					
	Y)		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Туре,	Print)			2 4 -	7					
	10			ne 2108	8 D, D	w	ah Prive	. Chite	MI	29d. Date signed (A 71/6/) ii 21(4/9						
	Sta		31. Date filed (Month, Day, Year) JUL 1 5 200	32. Pégistra	r's Signature	5	Sparks									
	Registr	ar	90F T 9 500	7	1		1.1									

			1 - For State Registrar	State of	Marylar		artment rtificate			and Me	ental Hygid Reg	ene 3. No. 0 0 Ly	22247			
	Physic	an	Decedent's Name (First, Middle, La Mollie Lyons	st)						2	2. Date of Death Month	Day Yea				
	/Medi Examir	cal	4a. Facility Name (If not institution, giv	e street and numb	oer)		4b. City, 1	Fown, or I	Location o	of Death	July 10,	4c. County of De	12:32pm M			
1	Exami	iei	5646 Old Washington F	bad	,		,		esvi1			Carro				
	Funeral Director		5. Social Security Number 238–50–6391 6. S	ex 7. □ M 2 1 7.	Age (In yrs.	last birthday) Yrs.	If Under	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day,) March 29		lirthplace (State or Foreign Country)			
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits			
	8a-f sho	Director	W	arroll					Syk	esvi11			1 Yes 2 No			
	th with ti 23a or 2 at be n	al Dire	10e. Street and Number 5646 Old Washington Road 10f. Zip Code 10g. Citizen of W USA									g. Citizen of What o	Country?			
9036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dreal Examiner must be multisd at	d by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Given Year or Date	es?	Was Decede f Yes, speci 1 Yes 2		panic Orio , Mexican Specify:	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)	14. Race - An Black, Wi Specify:	nerican Indian, nite, etc. white				
1215-(d within 72 hours piene. r than "natural", ir s Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								Kind of Business/Industry					
Maryland 21215-0036	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last, D.W. Jackson	0			ustodia				First, Middle, Ma Strickla	,	cian			
Baltimore, Maryl	12 sh h and 7 Is m traum	-	19a. Informant's Name/Relationship (Melvin Lyons / Husbo								Route Number, C Ykesville	City or Town, State	, Zip Code)			
	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 32© 1 ☐ Donation 5 ☐ Other (Specif		ate _ c	Place of Dispo cemetery, cren	natory or oth	her place,	1	Dat 1 y 14,		Rockwood				
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Euneral Service Licen		F	Jr. ch	Name and	Address Ste	of Facility	- Funera:	l Home, In timore MD	nc.				
	Physician /Medical Examiner	iner	23a. Part1. Enfer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause, (Disease or injury)	a. Seven	n line.	vsema wid				cardiac or r	espiratory arres	t,	Approximate Interval Belween Onset and Death YEARS			
68760,	death certificate be executed e attending physician and id for use as the buriat-transit	edicai Examine	resulting in death) Last Due to (or as a consequence of):													
O. Box 6	the death cert y the attending ached for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②▼No 9 ☐ Unknown		Ectopic pre Other (spe				23d. Date of delivery Month Day Year							
rds, P	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fib., Hypothyroidism								23e. Did tobacco use contribute to the cause of dea					
of Vital Records,	The law ate has b page 2 sł	Completed	24a. Was an autopsy performed 1 □ Yes XXX									d? prior to death?	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 250 No			
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)												
on of	ding h. After fune	tlon; To	1 Yes 225 No 27. Manner of Death 125 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?						280	me 5XXResidence 6 Other (Specify) 28d. Describe how injury occurred					
Division	I or Attending after death. Director: Afte	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								Rural Route Number,					
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the be niner: On the basi and manner	s of examina	wledge, death tion and/or inv	occurred at estigation, i	t the time n my opir	, date and nion, death	d place, and h occurred	d due to the caus at the time, date	se(s) and manner a and place, and du	is stated. e to the cause(s)			
•	To the within 24 To the Complete	Me	29b. Signature and title of certifier	m. I.	tim	Mla V	29c.	License r	number	5	29d.	Date signed (Mon	oth, Day, Year)			
	1X				completed cause of death (Item 23a) (Type, Print)											
			Charles Hegsgen, MD				-		estmin	ster M	D 21157					
	Sta Registr		JUL 1 5 2004	31. Date filed (Month, Day, Year) 32. Registrar's Signature Apacks												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joseph Nicholas Lauer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 9115 A Pulaski Hwy Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Say 8. Date of Birth (Month, Day, Year) Jan.10 1938 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 10M 20 F Days 219-26-2545 66 Director Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ebov other traumatic event, the Modical Examiner must be notified at 28a-fehow 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9115 A Pulaski Hwy United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If item 27 is marked other than nany injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) 8 Paper Cutter Printing Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Nicholas Lauer Anna Romeo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9115 A Pulaski Hwy Baltimore, Maryland 21220 <u>Patricia Lauer/Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory July 16,2004 Beltsville, Maryland M+698C 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral, Service Libense 8717 Green Pastures Dr Baltimore, Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **>** Physician eno vas 0 year S /Medical Due to (or as a consequence of) Examiner Olos u lono nari WOULC pars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician; The law requires that the death certificate be executed the attending physicien and shed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s certificate 2 M No 1 ☐ Yes 25. Was case referred to medical examiner?
12 Yes 2 □ No Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) ၉ 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred . After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director; A d in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral [1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and little of centrier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 6 Maryland 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar 1 5 2004

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r	4a. Facility Na									n, or Location of	f Death			4c. Count	•		
	5. Social Secu				er @ G		ge (In yrs. Ia	ast birthda	TOWS	SON ar If Under 2	24 Hrs.	8. Date of B	irth			more	or Fo
	215-22-	,			1 M 2 □	-	73	Yrs.	Months Day	ys Hours	Min.	(Month, D ${ m July}~1$	дау, Үө	ar) 1930		hplace (State untry) Vland	0, 10
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Director	Maryland Harford 10e. Street and Number				١	Bel Air				θ			10a.	Citizen of	en of What Country?		
	117 A Donzen Drive								210					USA			
Funeral	11. Marital Status					Decedent od Forces?	Ever in U.S	S. 13	B. Was Decedent of If Yes, specify C	of Hispanic Orig	in? (Spec	cify Yes or N	lo-	14. Rad	ce - Amer	rican Indian,	
y Fu			ed 2 X M		120Y	res 2 ☐ s, Give			1 ☐ Yes 2X f		1 46/101	tioari, stc./		Specif	ick, White	э, etc.	
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E O	⊨iementary	12	ndary (0-12	:)	Colle	ge (1-4or	D+)		Military	7			U.S	S. Ai	r Fo	rce	
Bec	17. Father's N	lame (First, Middl	le, Last)						's Name	(First, Middle				7.00	
0	Paul											Regi					
	19a. Informar Doree			nship (Type, Print,)		19b. Ma	iling Address (Stre	et and Number	r or Rural	Route Numb	ber, Cit	ty or Town,	, State, Z	(ip Code)	
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State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician AHMAN JULY 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MORE NORTHWEST RANDAUSTOWN SUBACUTE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) g. Birthplace Country) **Funeral** Hours Days 1**X** M 2 ☐ F 67 Director 01 Paki 04 212-68-4994 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be nutilised at 1 ☐ Yes 2 XNo Director Owings Mills MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 'natural', or Items 23a 2111**7** U.S.A. 211 Isinglass Lane Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: Specify: þ Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry East Coast Health Elementary/Secondary (0-12) College (1-4or 5+) 4yrs+ Medical Administration Organization 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 Mian Mohammed Asghar Hameeda Begum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isinglass Lane, Owings Mills, Md 21117 211 Kashif Ahmad-Son 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 7/14/04 Randallstown, Md 21. Signature of Funeral Service License 22. Name and Address of Facility
March F/H West 21215 <u>4300 Wabash Ave, Baltimore, Md</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MLMON **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No the 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 90 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No e DNo 1 Yes 1 TYAS Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of D ath 28c. Injury at Work? After Certification 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after deatle Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NHC NAVI MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 1 5 2004

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			Decedent's Name	e (First, Middle, L	.ast)							2. Date of D	Death	CUI] iq	2. Time of	Qath	
	Physici /Medic		David	Michael	l Martin							July	8		Year 2004	7:47	A^{M}	
	Examin		4a. Facility Name (I	f not institution, g	ive street and number)						on of Death	1	40	c. County	of Death			
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30%	Funeral Director		212-76-10 Usual Residence of)38	Sex 1 M 2 □ F	42	Yrs.	Months		Hours		B. Date of E (Month, I May 10), 19	62	COL	y Land	- Toroign	
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Baltimore, Maryland 21215-0036	Toa. State 10a. State 10b. County MD N/A 10a. Street and Number 5038 Federal Street 10b. County MD N/A 10c. Street and Number 5038 Federal Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 KDivorced 15. Decedent's Education (Specify only highest grade comp. 15. Decedent's Education (Specify only highest grade comp. 15. Decedent's Education (Specify only highest grade comp. 16. Specify only highest grade comp. 17. Father's Name (First, Middle, Last) Rupert Walker 19a. Informant's Name/Relationship (Type, Pr.					5+)	1	во мот taker				Residen			tial			
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e,	1 and Healt tem 2		Mageline 20a. Method of Dis		in - mother		Place of Disponentery, cre				et, r	Baltimo:	-		21205 City or T	own, State		
<u>a</u>	permit. Pages 1 and 2 should be Depa tment of Health and Menta Importent: If item 27 Is marked any injury or other traumatic es		1 ☐ Burial 2 `4 ☐ Donation	Cremation 3 Other (Spec	Removal from State	d'	nesapeal				7/13	3/2004	Be	ltsv	ille,	MD		
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Ò.	that the de ed by the a detached t	hysi	9 Unknown		9□ Unknown			Ì										
ds, P	The law requires that the death certificate be site has been signed by the attending physicic page 2 should be detached for use as the bu	by	Part II. Other signif		contributing to death t	out not res	sulting in the	underlying	cause giv	en in Pa	rt I.		tobacco Yes 2		ribute lo l	he cause of c	leath? Jnknown	
cor	w requ	lete							-			24a. Wa	ıs an	24b.	Were auto	opsy findings	available	
Re		Completed	<u></u>									per	opsy formed? 2 \(\sum \)		prior to co death? 1 X Yes	empletion of c	ause of	
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Division of Vital Records,	To the Hospitel or Attending Physicien: Alinin 24 hours after death. To the Funerel Director: After this certification of the Funerel Director. Completely filled in by the funeral director.	Certification:	3 Suicide 4 Homicide	6 Could not determine		jury - At h tc. (Specil	ome, farm, s fy)	treet, facto	ory, office			28f. Location Cify or T	(Street a		er or Run	al Route Num	ber,	
	spitet o		29a. Certifier	1 ☐ Certifying	Physician: To the best	of my kno	owledge, dea	ath occurre	d at the tir	ne, date	and place	, and due to th	e cause(s	s) and ma	anner as s	stated.		
	To the Hospite Within 24 hours to the Funerel completely filled	Medical	(Check only one)	2 Medical Ex	aminer: On the basis of and manner st	of examina	ation and/or i	nvestigatio	on, in my o	pinion, d	leath occu	rred at the time	e, date ar	nd place,	and due t	o the cause(s)	
	2 6	Σ	29b. Signature and	I title of certifier	" "				9c. Licens	e numbe	ər					Day, Year)		
	Shop		Yang	PHY MIT	no completed cause of	death /Ites	n 23a) (Tues		OCME	<u> </u>			JU.	ту 9	, 200	14		
	. J. Ch.		Pamela	E. Gasth	all, M.D.		11		n St	reet	, Bal	timore	, Mai	ryla	nd 21	201		
1	Sta Registi		31. Date filed (Mon	nth, Day, Year)	32. Regist	rar's Signa												
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle 1 ast) 3 Time of Belath July 13^{pay} **Physician** 2004 8:10a Millie Edith Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Manor Health Care Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Apr 30, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 A 6. Sex Year) 1910 **Funeral** Days Hours 1 □ M 2 💢 F 94 Yrs. Director 217-28-1961 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Md Howard Lisbon Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15940 Frederick Road 21765 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Itel any njury or other traumatic event, the Nedical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lilly Cope James B. Wilder ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Mitchell Helton (daughter) 1370 Florence Rd., Mt.Airy, Md 21771 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State 7-17-04 Liberty Baptist Cem. Lisbon, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HOME & CHAPEL, PA (Box 195) Buan Vac Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed ALZING IMEAS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown certificate hes been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 A Nersing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-13-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD MILLER MD, 4 CULWELL DR MT. AIRY MD 21771 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 1 5 2004

			1 - For State Registrar	State of M	larylan		artmen rtificat			and M		Reg. No.)	nn	The state of the s	222) E o
	Physici	an	Decedent's Name (First, Middle								2. Date of Dea Month	Day		'ear	3. Time of	
	/Media		Terrie Ann								July	13		004	12:18	8 A ^M
7	Examir	er	4a. Facility Name (If not institution,						Location of	of Death		4c. C	ounty of			
-			Pulaski Highway 5. Social Security Number			last birthday)	If Under	Ltimo	ore	24 Hrs.	8. Date of Birt	h	N/A		lace (State o	or Coming
	Funeral Director		3. Social Security Number	1 M 2 XF	41	Yrs.	Months		Hours	Min.	Oct. 5	y, Year)		Coun	yland	or r-greign
	pu ,		Usual Residence of Decedent		10-0"	T										
	aryla	-	10a. State 10b. County			y, Town or Lo								1	0d. Inside Ci	2 ☐ No
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	with t	Funeral Director	10e. Street and Number				10f. Zip		221			10g. Citize			try ?	
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	ter d	Ę	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Forces	?	.5.	If Yes, spec	cify Cuba	in, Mexican	i, Puerto	ecify Yes or No- Rican, etc.)			White,		
99	urs al	by	3 ☐ Widowed 4√ Divorced	If Yes, Give Year or Dates:			1 Yes	2 X 10	Specify:			S	pecity:	Wh	ite	
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	be filed within 72 hours after death with the Marylan ital Hygiene. Id othar than "natural", or Items 23a or 28a-f show evant, the Medical Evantian must be notified at	Completed		3		Secr	etary	7				Medi		Off	ice	
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<u></u>	should be nd Mental marked o	은	Earl Wallace					-		othy			neng			
Maryland	2 sh and is rr		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	er or Rur	al Route Numbe	r, City or	Town, St	ate, Zip	Code)	
Baltimore, I	Pages 1 and 2 should tent of Health and Men nt: If itam 27 is marke iry or other traumatic		Farl Moore / F. 20a. Method of Disposition 1 Burial 2X Cremation		1 0	1584 Place of Disponentery, cremetery, cremetery	sition (Nan	ne of		ive,	Virgin:				rginia wn, State	2346
ţ	t. Pa tmen tant: ijury	. 0	'4 □Donation 5 □Other (Sp		Hi	11top	Servi	ce (orp.	7-1	5-04	Tows	on,	Mar	yland	
Bal	permit. Page Department Important: In any injury o		21. Signature of Funeral Service L	ducky		22	McCon 1317	nas I Coke	unera sbury	1 Ho	ome, P.Z ad, Abii	A. ngdon	, MD	21	009	
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		0 B	examiner? 1X Yes 2 □ No	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatier	nt 3 DC	Oth			me 5 Resid		XOther	(Specify	at sc	rene
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Division	I or Attand after death Diractor: , d in by the f	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Place of In	_	ome, farm, str		, office			28f Location /S	treet and	Number	or Rura	Houte Name	Der,
Ö	tal or	Cer		Danowig, C	rc	ad				1	Monumer	+ St.	BIL	tine	one H	D
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) Medical I	g Physician: To the besi examiner: On the basis and manner s	of examina	wledge, deatl tion and/or in	h occurred vestigation	at the tin , in my o	ne, date an pinion, deal	d place, th occurr	and due to the d ed at the time, d	ause(s) a date and p	nd mann lace, and	er as sta due to	ated. the cause(s))
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	X		30. Name and address of person of the state	XGAN)		111		Stı	æt,	Bal	timore,	Mary	land	212	201	
	Sta Registi		31. Date filed (Month, Day Year)	2004 34 Regist	rar's Signa	iture	100									

DHMH 17 Rev 1/2001

ORIGINAL

			101	partment of Health and Me ertificate of Death	ental Hygiene	22251							
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death							
	/Media	cal	Rosalie A. Messina		July 13 2004	1903 ^M							
1	Examir	ner	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster	4c. County of De	ath							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo			irthplace (State or Foreign							
	Director		220-12-9395 1 M 2 TF 91 Yrs	Months Days Hours Min.	Month, Day, Year) Aug 31 1912 Md	Country)							
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits							
	Maryla f sho	0	Md Carroll Elders			1 ☐ Yes 2 🛣 No							
	the r	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	Country?							
	th with	al D	6228 Longleaf Pine Road	21784	USA								
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evant are must be coulled at	Funeral	Armed Forces?	3. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.) 14. Race - Arr Black, Wh								
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: W	hite							
ò	2 hou	ted	15. Decedent's Education 16a, De	cedent's Usual Occupation	16b. Kind of Busines								
21215-0036	within 7 iene. than "r	Completed	Elementary/Secondary (U-12) College (1-40r5+)	ive kind of work done during most of working DO NOT use retired)	ļ								
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ore	0 0	1	comoton, c	position (Name of permatory or other place)	te 20c. Location - City o								
ţ	Department of I Department of I Importent: If its any injury or or once.		Discrepancy of State Commentary of Other Place) Donation 5 □ Other (Specify) New Cathedral Cem. 7-17-04 Baltimore, Md										
Bal	permit. Pag Department Importent: I any injury o		▶ Parge Haight Herbert	ille, Md 21784	& Chapel								
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between Onset and Death							
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8760,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):										
387	physicate to the the the the the the the the the the	dlca	d										
Box 6	death certificate be executed e attending physician and id for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	alivery							
	s death he atte ed for	Physician/Medical	1 Yes 2 PNo 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	Month	Day Year							
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alE		O			performed? death? 1 Yes 2 No 1 Yes	s 2 No							
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o t	ding Phye h. After this funeral di	⊢	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	d. Describe how injury occurred	эспу)							
ioi	Attending r death. ector: After by the funer	atlo	2 Accident investigation	M 1 Yes 2 No									
Division	in Direct	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28	3f. Location (Street and Number or Fi City or Town, State)	ural Route Number,							
	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	ledical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, de 2. Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cause(s) and manner a d at the time, date and place, and du	s stated. e to the cause(s)							
	To t To t comp	Σ	29b. Signature and title of confider	29c. License number	29d. Date signed (Mon	-							
•	, 1			D34849	July 15, 6	1004							
	5			e, Print) Liberty Rd Eld.	ersburg, MD a	1784							
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hade									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Day JULY 12, **Physician** Year MCGUIRE 2:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 33 OLD FARM ROAD GLEN BURNIE ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) JAN. 18, 1932 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min 1□M 2√F 72 Yrs. Director 213-30-4661 Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f show Item: ust be notified at 1 ☐ Yes 2 No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 33 OLD FARM ROAD 21060 USA 2 should be filed within 72 hours after death v and Mantal Hygiene. Is marked other than "natural", or Itams 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER FRAME & ART GALLERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOUIS JULIUS SAMUELS SARAH AGRANOVITZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trains once. 33 OLD FARM ROAD - GLEN BURNIE, MD 21060 RALPH F. MCGUIRE / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ⁴ □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM: 7/14/2004 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit the Hospitel or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown 1 TYes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ۲ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Sescribe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funaral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) PS State Registrar

			1 For State	State of M	aryland / Depa 7-28- 26033	artment of H	lealth and	d Mental Hy	giene		
F	9		Registrar Amend ite 1. Decedent's Name (First, Middle,	441/	nfG833	tillicate of	Dealii	2. Date of De		004	3. Time of Deale
	Physici /Medic		Donald Edward N	ichles Ir				Month	Day 12	/ Year 2004	4:30 FM
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of D	eath		County of Deat	
			Union Memorial			Baltimo			n/		
	Funeral Director		217-60-0062	7. Ag 1 ☐ M 2 ☐ F	ge (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days		1 8. Date of Bir (Month, Dir 9/5/19	ay, Year)		hplace (State or Foreign buntry) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Mary Fied	to	MD Harford	1	Edgewood	l					1 ☐ Yes 2 🙀 No
	ith the Marylan or 286-1 show	irec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?
	ath wi	rai	1938 Mark Dr.			21040			Unit	ed Stat	es
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28e-1 show other traumatic event, the Medical Examinations to confilted at	by Funeral Director	11. Marital Status 1 □ Never Married 2 X Marrie 3 □ Widowed 4 X Divorced	12. Was Decedent Armed Forces d 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? an, Mexican, Pu Specify:	' (Specify Yes or No Jerto Rican, etc.)		14. Race - Ame Black, White Specify:	
21215-0036	2 hou	ted t	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation		16b. Ki	nd of Business/	Industry
215	hin 72 9. 9n "nu	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	life	kind of work done DO NOT use retired	during most of i)	working			
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Maryland	12 should be filed v n and Mental Hygie 7 is marked other t raumatic event, L.	Be	17. Father's Name (First, Middle, La	*				Name (First, Middle		Sumame)	
Z	nould I Men narke	2	Donald Edward N					en Harris			
Mai	d 2 st th and 7 is n traun		19a. Informant's Name/Relationshi					Rural Route Numb			
Baltimore,	Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other then ary or other traumatic event, I amb		Kathleen M. Mil 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	cemetery, crer	sition (Name of natory or other plac	(e)	rbutus, M	20c. Lo	and 212 cation - City or	2.7 Town, State
Ħ	- 5 th 5		' 4 ☐ Donation 5 ☐ Other (Special Service Li	**	Bayview (Crematory . Name and Addre		4/2004	Bal	timore,	Maryland
Ba	permi Depar Impo any ir		Ilan D	Sullino				Ambrose F	uner	al Home	, Inc.
			23a. Part1. Enter the disease, or co	omplications that cause	the death. Do not ent	er the mode of dyin	g, such as card	liac or respiratory a	rrest,	us, mar	yland 21227 Approximate Interval Between
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	,							Onset and Death
	/Medical		resulting in death)	a. Sep Due to (or as	a consequence of):						2 weeks
	Examiner		Sequentially list conditions,	b. Squa	movs Cell	Career of	Esuph	evs			10 menths
	ad sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	and all-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
8760,	icate be executed physician and s the burial-transit	dicai E			,						
9	ifficate g phy: as the	0		0.							
Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year
P.O.	that the de ted by the a	hys	9 🗆 Unknown	9□ Unknown							
Records, F	w requires that been signed should be de	by	Part II. Other significant condition	s contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.				the cause of death?
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E		Con						perfo	rmed?	death?	_
Vital	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?	Literates.				Death Check on c			
o	Phys this ral di	<u>۲</u>	1 Yes 2 No	Hospital: 1 X Inpatie				Home 5 Resid	dence 6	Other (Spec	ify)
Division	ding F h. After funer	Certification:	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y Year) Injury	Worl		28d. Describe i	10w injury	occurred	
/İSİ	or Attend after death Director: /	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Inj	ury - At home, farm, str			28f. Location (S	Street and	l Number or Rui	ral Route Number,
Ö	s afte	Sert	4 - Homicide determin	building, et	c. (Specify)	,		City or Tox	vn, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis o and manner st	f examination and/or inv	occurred at the time vestigation, in my of	ne, date and pla pinion, death or	ace, and due to the courred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	2.11		29c. License	number		29d. Date	signed (Month	, Day, Year)
)	1		there.	Rolling,	no	P.TZ	438946	214	Jul	9 12, 20	24
	18		30. Name and address of person wh	no completed cause of c	leath (Item 23a) (Type,	Print)					
	V		31 Date filed (Month Day Your)	, My 201	E. University	Perkusay,	Baltim	ore, mp 2	218		
•	Sta Registr		Steven Rottman 31. Date filed (Month, Day, Year) JUL 1 5 2004	Serve	ar s Signature	books					

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/Medical Examiner 4a. Facility Name (If not Johns Hopk	institution, give street and r	1/12/42/10	ממ			2. Date of De. Month	Day	3. Time of Death
Johns Hopk	-		771	4b. City, Town, o	r Location of Dea	June	2.7 2.0 4c. County o	004 13:19 M
E. Casial Cassists Missel	ins Bayview.		Zenter	Balt			40. County o	Dodui
Funeral Director 5. Social Security Numb 213-52-1913	er 6. Sex 1 ☐ M 2 X F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hr. Hours Min		th ly, Year) [948	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Dec	b. County	10c. City	, Town or Lo					10d. Inside City Limits
MD Stor			BALT	IMORE				1 X Yes 2 □ No
the Main the	ER WAY			10f Zip Code 21205			10g. Citizen of Wi	nat Country?
10a. State MD 10a. State MD 10a. Street and Number 10a. Street and Number 10a. Street and Number 10a. Street and Number 10a. Street and Number 935 SPANGI 11. Marital Status 11. Marital Status 12. Specify of Elementary/Secondar 13. Specify of Elementary/Secondar 14. Father's Name (First ERI 19a. Informant's Name. PAUL J. NEW 20a. Mathod of Disposit 12. Burial 2 Co. 13. Street and Number 14. Specify of 15. Specify of 16. Specify of 17. Father's Name (First 19a. Informant's Name. 19a. Information of Name. 19a. Information of Name. 19a. Information of Name. 19a. Information of Name. 19a. Information of Name. 19a. Info	2 Married Armed	ecedent Ever in U.S Forces? s 2		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Black	- American Indian, White, etc. WHITE
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PAUL J. NEW PAUL J. NEW 27 Jan 18 Jan	Relationship (Type, Print) VLON-HUSBAND			SPANGLER				
20a. Method of Disposit 1	remation 3 🗆 Removal from	m State Ce	emetery, crer	sition (Name of matory or other plac CEMETERY	7/2	Date 2/04	20c. Location - C	ity or Town, State W.VA
But a 2 Go of the street of th	p Cvach per	DVR		2. Name and Address	-			UNERAL HOME 1237
shock, or heart ta Immediate Cause (Fina disease or condition resulting in death) Examiner Sequentially list condition and the sequential of the sequential or sequentia	ons, b. Due to	n each line. Ardiac to (or as a consegu	, Ari	er the mode of dyin rest enal			rrest,	Approximate Interval Between Onset and Death
studence parallinear training in death) Last call Example 1. C	c. Due t	o (or as a consequing of the c	1)10K 1900 of): 4 A	etery i	isease	2		
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law requires that as been signed by Prince by	t conditions contributing to	death but not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to		ute to the cause of death? Probably 4 □Unknown
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Physician The Ph	Hospital:		<i>(</i>	t 3 DOA Oth		ath Check onl or		
T A SEPTION TO SEPTION	11		R/Outpatien 28b. Time of	IL JUDON	4 🗀 Nursing i	4	lence 6 Other	
Attending Party 1 27. Manual of Death	Pending (Mo	onth, Day Year)	Injury		k? Yes 2 □ No		, ,	
	Could not be determined 28e. Pla	ce of Injury - At hor Iding, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number m, State)	or Rural Route Number,
29a. Certifier 1	Certifying Physician: To t Medical Examiner: On the and ma	the best of my know basis of examination	vledge, death ion and/or inv	n occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the durred at the time, d	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
the second secon	of certifier	MO		29c. License	number	57	29d. Date signed (Month, Day, Year)
30. Name and addre is	of person who completed ca		23a) (Type,	Print)	X/1-1	1 Te 14	n. Ita	Mad 2 177)
State 31. Date filed (Month, D	5 2004 B	. Registrar's Signatu	ure A	Soorts!		6	130010	114 7122

			State of Maryl	-	rtment of He			iene .g. N. ? () () ()	22250
			Registrar 1. Decedent's Name (First, Middle, Last)		anouto of D	Cairi	2. Date of Deat	h	3. Time of Death
	Physici		Elizabeth Jane	Orași e	ac		Month	Day Year	2:30 P M
5	/Medic Examin		4a. Facility Name (If not institution, give street and number)	e Owir	4b. City, Town, or L	ocation of Death	July 9	4c. County of Deat	
	LAGITIT	CI	808 Umbra Street		Ral+i	more City	. 7	N/A	
	Funeral			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	thplace (State or Foreign
	Director		216 - 36-5577	Yrs.	Months Days	Hours Min.	(Month, Day, June 19		aryland
	pc ,		Usual Residence of Decedent	. City, Town or Lo				7	
	aryla shov	-	10a. State 10b. County 10c. Maryland N/A	. City, Town of Lot		ltimore (71+		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	Director				TCTHOLE (0. 0.0.	
	Mith t	ä	10e. Street and Number		10f. Zip Code			0g. Citizen of What Co	ountry ?
	s 23	Funeral	808 Umbra Street 11 Marital Status 12. Was Decedent Ever i	in II S 12 V	Vac Decedent of His	21222	cifu Ves or No-	United 9	
	Item Iren	Ľn.	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	15.0.	Vas Decedent of Hisp Yes, specify Cuban,	Mexican, Puerto F	Rican, etc.)	Black, Whit	
336	urs at	by	3 ☐ Widowed 4 Divorced If Yes, Give Year or Dates:	1	☐ Yes 2⊠ No	Specify:		Specify: V	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ather than "neturel", or ttems 23a or 28a-f show ont, the Medical Examinet must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupati	ion		16b. Kind of Business/	Industry
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7	er th	Completed	12 Years	H	omemaker			Own Ho	ome
p	be file	Be (17. Father's Name (First, Middle, Last) John Kutchey		1	l8. Mother's Name منت		·	
<u>ya</u>	Ment Ment arke	၉	John Racelley			пе	elen Str	ycnacz	
Maryland	2 should and Mer Is marke reumetic		19a. Informant's Name/Relationship (Type, Print) Son I					City or Town, State, 2	Zip Code)
2	and tealth m 27 her t		Mr. Edward Peddicord/ Law		Umbra Str		-		21224
OLE	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 Is marked other than "neturel", or Items 23a or 28a-1 show or other treumetic event, the Medical Examiner must be notified at		20a. Method of Disposition 20 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	sition (Name of natory or other place)		ale	20c. Location - City or	Town, State
Ē	. Pa tmen tant: jury				ary Cemet		1/2004	Dundalk,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tre		21. Signature of Funeral Service Licensee	22 D	. Name and Address uda-Ruck 1	of Facility Funeral H	Home of	Dundalk, I	nc.
	40200		Constitution of the disease of the disease that coursed the	79	22 Wise A	ve. Duno	dalk, Ma	ryland 21	222 Approximate
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9	ntifica ng ph as th	0	IF FEMALE:			-			
Вох	death certifica attending pla afor use as t	an/l	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of del	ivery Day Year
	e dea the at	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	of death 5	Other (specify)				Jay Vou
P.0	that the death red by the atter detached for t	Phy	Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause given	in Part I	23e. Did tob	acco use contribute to	the cause of death?
S,	signe	i by	Tall II. Gallot organization of the balling to double out the		iconying cases given			s 2 No 3 Pr	
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a		O					1 ☐ Yes 2	No 1 □ Yes	2 No
Ħ Z	Physicien: The this certificate haral director, page	Be	25. Was case referred to medical examiner?		Other	26. Place of Death	1		
of	Phys r this ral di	- T	1 Yes 2 No 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien	t 3 DOA 28c. Injury a	4 Nuising non		nce 6 Other (Spec w injury occurred	city)
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Division	Attending ir death. ector: After by the fune	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury		eet, factory, office	2		reet and Number or Ru	ral Route Number,
á	after Direction	Certification;	4 Homicide determined building, etc. (Sp	secity)			City or Town	, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1—Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam	knowledge, death	occurred at the time	, date and place, a	and due to the ca	use(s) and manner as	stated.
	he H in 24 he Fu	edical	one) and manner stated.	mination and/or inv					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	ANX	29c. License			d. Date signed (Mont)	
7	,/		IN The Unday	1011)	D 5	9032		7-12-5	2004
	5		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	11/ 00 0	Y 1	111 0	Mardand 21231
			31. Date filed (Month, Day, Year) 32. Registrar's S	Upkinj Hos	104 INTIG	100011	1 wavey	On Himse,	argland 21231
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		State of Maryland / Department / Department / D		Mental Hygie	ene
Physicia /Medic		Decedent's Name (First, Middle, Last) Cornelius	Pressley	2. Date of Death Month JULY	Day Year 9 2.004 8:33 P
Examin	er	4a. Facility Name (If not institution, give street and number) SINAI HOSPITM OF BALTIMOLE	4b. City, Town, or Location of Deal BALTIMORE CIT		4c. County of Death
Funeral Director		5. Social Security Number 214-64-1126 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) 58 MD
with the Maryland e or 28a-f ahow	ctor	10a. State 10b. County 10c. City, Town or Lo MD NA Baltim			10d. Inside City Limits 1 ☑ Yes 2 □ No
death	by Funeral Director	1 X Never Married 2 Married 1 X Yes 2 No	10f. Zip Code 21218 Nas Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puer Yes 200 Specify:		Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Placels
72 hc	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16t	Black D. Kind of Business/Industry
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ss 1 and 2 should of Health and Mer item 27 is marke r other traumatic		Brenda Pressley-Sister 4016 20a. Method of Disposition 20b. Place of Dispos	g Address (Street and Number or Ric Maine Ave Ba sition (Name of latory or other place)	ltimore,	Maryland 21207 C. Location - City or Town, State
permit. Pages 1 and 2 Department of Health a Important: It item 27 is any injury or other tra		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee **A Donation 5 Device Licensee / A Representation 1 State **A Donation 5 Device Licensee / A Representation 1 State **A Donation 5 Device Licensee / A Representation 1 State **A Donation 5 Device Licensee / A Representation 1 State **A Donation 5 Device Licensee / A Representation 1 State **A Donation 5 Device	morial Park 7/ Name and Address of Facility arch F/H West	16/04 R	andallstown, Md
20E 29		23a. Part Enter the brease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	300 Wabash Ave	Baltim c or respiratory arrest,	Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. DICSEMINATED Due to (or as a consequence of):	INTRAVASCULAR	COALULA.	Onset and Death
e be sicia e bur	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lue to (or as a consequence of): c. Due to (or as a consequence of):			
Attending Physician: The law requires that the death certificat rideath. rideath. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
quires that in signed b	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 \(\sum \) No \(3 \sum \) Probably \(4 \sum \) Onknown
The law requirate has been sipage 2 should	Completed	DIABETIS MELLITUS		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
anding Physician: The lath. After this certificate hate funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	0.1	ome 5 Residence 28d. Describe how in	6 □Other (Specify) njury occurred
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, St	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death (2 Medical Examiner: On the basis of examination and/or invessed and manner stated.	estigation, in my opinion, death occur	rred at the time, date a	and place, and due to the cause(s)
or Mili	2	29b. Signature and the of certifier	29c. License number		Date signed (Month, Day, Year)
1		30. Name and address of person vito completed cause of death (Item 23a) (Type, PMARIA STEPHANIE R. JARDELEJA M.	rint)		
Stat Registra	e	31. Date filed (Nonth, Day, Year) 32 Registrar's Signature	D SINAL HOSPIT	LAL OF BY	TLIMUKE

State of Maryland / Department of Health and Mental Hygiene

	Otat	Convictional	Certificate of D		Reg. No.	22260
a Physician	1. Decedant's Nama (First, Middla, Last)			2. Data of the Month	Death Day Yea	3. Tima of Death
 Physician /Medical 	CATHERINE P.	ORTERA		フレム		+
Examiner	4a Facility Nama (If not institution, giva street ar	id numbar)		. City, Town, or Location of De		
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Funeral Director	5. Social Security Number 200–18–5019 6. Sax	7. Aga (In yrs. last birth) 76 Yr	Months Days	Hours Min. 8. Data of E. Montb. April	28, 1928	Birthplaca (Stata or Foreign County) West Virgini West Virgini
Man Man	10a. Stata 10b. County	10c. City, Town	or Location			10d. Insida City Limits
n the Marylen r 28a-1 show incitting at	Md. Baltimore	Reister	rstown			1 ☐ Yas 2 ☐XNo
) iter death with the Ma r ttems 23s or 28s-1s ites must to notified Funeral Director	10e. Street and Number 1906 Shawan Valley	Lane	10f. Zip Code 21136		10g. Citizen of What	Country? JSA
S 2 3 3	Arm 1 □ Navar Marriad 2 □ Married 1 □ 1 □ Ye 3 🔀 Widowad 4 □ Divorced Yea	Dacedant Ever in U,S. ed Forcas? Yas 2 XNo es, Giva r or Datas:	13. Was Decedant of His If Yas, specify Cuban 1 ☐ Yas 2 ☑ No	panic Origin? (Specify Yas or I , Maxican, Puarto Rican, atc.) Specify:	Black, Wi	narican Indian, nite, atc. Nhite
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Ind 21215-0 be filed within 72 hos tal Hygiene, to other than *natura went, ma Medical.	Elamantary/Secondary (0-12) Colle	000 /1 /0r E i	ifa. DO NOT use retired) lerical		Stee1	
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Be Be	17. Fathar's Nama (First, Middla, Last)			Irene Mostr		
Tyla nould to the market nettic		40-1	Mallion Address (Ctrant o	nd Number or Rural Routa Num		Zin Codo)
Maryland d 2 should be file the and Mental Hy 27 Is marked othe traumatic event.	19a. Informant's Name/Relationship (Type, Prin Mrs. Irene Kaminaris/			Valley Lane Re		
Heal Heal	20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date	20c. Location - City	
Baltimore, Maryland 212: permit. Peges 1 and 2 should be filed within popartment of Health and Mental Hygiene. Important: If them 271s mericed other than any Injury or other traumatic event, tra H once. To Be Comp	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)		metrios Ceme	etery 7-16-04		, Md.
Ball Permit Import any In	21. Signatura of Funeral Service Licensaa	3		on Funeral Home Rd. Towson, Mc		
	23a. Part1. Emar tha disaasa, or complications shock, or haart failura. List only one cause	that caused the daath. Do no on eech line.	t antar tha mode of dying	, such as cardiac or respiratory	arrest,	Approximata Intarval Batwaan Onsat and Daath
Physician /Medical	Immediata Causa (Final disaasa or condition	CUTE NUI	cla Genou	IS LEUKE	MIA	MONTHS
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(68760, riflicate be executed no physician and res the burial-trensit	Sequantially list conditions,	Dua to (or as e co	nsequance of):			
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P.O. BOX nat the death ce d by the attendi lateched for use Physician/	Part II. Other significant conditions contributing	to death but not resulting in t	ha undarlying cause give			ta to the cause of death?
that that the sed by the datach]Yes 2□No 3□	Probably 4 Junknown
of Vital Records, P.O. Box Physician: The law requires that tha death cer this certificate has been signed by the attendir rel director, page 2 should be datached for usa i: To Be Completed by PhysicianA				24a. Wa	as an autopsy 24b formed?	b. Were autopsy findings available prior to completion of cause of death?
of Vital Recoverable of Vital				*E	Yas 2000	1 ☐ Yes 2 ☐ No
/ital	25. Was case referred to medical			26. Place of Death (Check only	(one)	
of Vita Physician: this certific rel director,	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other	T: 4☐ Nursing Homa 5☐ Ra	sidance 6 Othar (Sp	pecify)
g Physerthis	27. Manner of Death 28a.	Dete of Injury (Month, Day Yaer) 28b. Tin	na of 28c. Injury	at 28d. Describ	e how injury occurred	
iior ndin eth. eth. e fur atio	2 Accidant invastigation	(Month, Day Fact)		as 2 No		
DIVISION (Ball or Attending P states deeth. al Director: Attent led in by the funer Certification:		Place of Injury - At homa, farm building, atc. (Spacify)	n, straat, factory, office		(Straat and Numbar or own, Stata)	Rural Route Numbar,
Division of To the Hospital or Attending Phywithin 24 hours after deeth. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification:	(Check only 2 Medical Examiner: On			e, data and place, and due to the nion, daath occurred at the time		
To the complex	29b. Signature and title of certifiar		29c. Licansa	numbar	29d. Date signed (Mo	nth, Day, Year)
- 3 - 3	SAINT	eMD	000	53150	Juu. :	3th 7004
(T)	30. Name and address of person who completed	cause of daath (Itam 23e) (T	Drint)			
\	SHAKUNMACA	GUPTAMD.	POBOX 6	303 ELLIC	077 0170	7 21042
State	31. Data filad (Month, Day, Yaar)	32, Registrar's Signatura	don't	303 ELLIC		

		_	State Registrar	State of Ma	ryland /	-	rtment tificate			and M		Reg. I	001	14	2226	
	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of I		^{Day} 2004	Year	3. Time of Dear	th I
	/Medic	al	Mary Jane Povle 4a. Facility Name (If not institution, give str				4b. City, T		L agetien :	4 Decath	July		4c. County		9:25 AM	/ M
	Examin	er	2368 Northcliff						svil			1	Harfo			
	Funeral		5 Social Security Number 6 Sex	7 Age	(In yrs. last t	birthday)	If Under 1	1 Year	If Under 2	24 Hrs.	8. Date of E	Birth			place (State or For	reign
	Director		212-03-6355	u 201 8	6	Yrs.	Months	Days	Hours	Min.	Feb.	$\stackrel{\scriptscriptstyle m Day,\ Year}{ m I}, \stackrel{\scriptscriptstyle m Year}{ m I}$	918	Mar	place (State or For	
	pu ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, To										Od Inside O'bell'	
	shov	5			•										10d. Inside City Lin 1 ☐ Yes 2 [7]	
	28a-f	ect	MD Harford 10e. Street and Number		Jarre	ettsv	10f. Zip (Code				100.6	Citizen of W	(hat Cau		
	Mith Ba or	Funeral Director	2368 Northcliff Dr	ive			210					_	Jnited		*	
	ms 2%	era		. Was Decedent E	ver in U.S.	13. V			panic Orig	gin? (Spe	cify Yes or h		14. Race	- Ameri	can Indian,	
9	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give	0		Yes, speci		, Mexican Specify:	, Puerto F	Rican, etc.)			k, White,	_{etc.} White	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Exaciner must be redified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:									Specify:			
5	"natu	Completed	15. Decedent's Educa (Specify only highest grade	ition co <i>mpleted)</i>	16	a. Deced	ent's Usual kind of work OO NOT use	Occupat done du	tion <i>in</i> ng most	of working	g	16b.	Kind of Bu	siness/In	dustry	
12	within ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		maker						Owr	n Hor	ne	
	filed Hygir other ent, I		17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Midd	le, Maid				
an	should be filed withir nd Mental Hygiene. merked other then imatic event, II.e M.	То Ве	Albert John Anders	on					Leno	ra		Moor	ney			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Modical Examiner mast be notified at		19a. Informant's Name/Relationship (Type	e, Print)	15	9b. Mailin	g Address	(Street a	nd Numbe	r or Rurai	Route Num	ber, Cit	y or Town, S	State, Zip	Code)	
	l and lealth		Robert W. Povleski	/Husband					load,		cton,		2111			
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Rei	moval from State		tery, crem	natory`or otl	her place			Ate		Location - (
ij	t. Pac tmen tent: tent:		* 4 □ Donation 5 □ Other (Specify)	(2)	нідп	_	Memor	TO STATE OF THE PARTY OF THE PA			/2004		allst			
Bal	permit. Page Department of Important: If any injury or	21. Signatur of Final Service Licenses 22. Name and Address of Facility Ruck Towson Funeral 1050 York Road, Towson, Maryland 212												c.		
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused caused line	the death. De	o not ente	er the mode	of dying	, such as	cardiac or	respiratory	arrest,			Approximate Interval Between Onset and Death	1
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oʻ	an an rial-tr		resulting in death) Last	Due to (or as a	consequenc	e of):										
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9	artifica ing ph e as t	Med	IF FEMALE:	=		-										
Box	leath certifica attending ph i for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	to If yes, outcome of 1 Live birth 2	2 🔲 Fetal dea		Ectopic pre						23d. Date Mon		ory Day Year	
o.	he de / the s ched i	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at t 9☐Unknown	ime or death	51_	Other (spe	спу)							·	
<u>α</u>	res that lhe death signed by the atter be detached for u	Y Ph	Part II. Other significant conditions contr	ibuting to death bu	t not resulting	j in the un	derlying ca	use giver	n in Part I.		23e. Dio	tobacc	o use contri	bute to ti	ne cause of death?	?
rds	quires n sigr ald be	d by									10] Yes	2010	3 🗌 Prob	abiy 4 Unkno	nwc
000	law requir as been si 2 should l	Completed									24a. Wa		24b. W	ere auto	psy findings availa	able
Re	ic ian: The lav certificete has rector, page 2	шо										opsy formed?	de	eath?	npletion of cause	ot
ita	ilan: ertifice ctor, j	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only					
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n	ding P h. After t funera	lon:	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b	. Time of Injury		c. Injury Work			8d. Describe	how in	jury occurre	d		
isio	Attanding r death. actor: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	n/ - At home	farm etre	M factors		es 2□ñ		Rf Location	(Street	and Numbe	r or Rum	l Route Number,	
Division of Vital Records,	after Dirac	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	iaiii, siie	ret, factory,	Office			City or T	own, Sta	ite)	r Or India	r rioute reunioer,	
-	To the Hospital or Atlanding Physician: The within 24 hours after death. To the Funaral Director: Atter this certificete hy completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	cian: To the best of er: On the basis of and manner stat	examination a	ge, death and/or inv	occurred a estigation,	t the time	o, date and nion, deat	d place, a th occurre	nd due to th d at the time	e cause e, date a	(s) and man	ner as s	ated. the cause(s)	
	To thi within To the	Me	29b. Signature and title of certifie	X			29c.	License	number			29d. [ate signed	(Month,	Day, Year)	
			Disker Q.	1)W	~><			700	1362	31		उ	WY	12	2004	
	V		30. Name and address of person who com	p eted cause of de	ath (Item 23a	(Type, I	. 17	OTO		NyD		212	-07			
	Sta		31. Date filed (Month, Day, Year) JUL 1 5 2004	32. Registra	r's Signature	1										
	Registr	ar	JUL I J 2004		M	gar	res.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and nur Examiner etimore 12a If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Number Age (In yrs, last birthday) 6. Sex **Funeral** Days Months Hours Min -38-5 1 ■ M 2 X F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Heatth and Mental Hygiene. Inten 7 is marked other than "natural", or Itams 23s or 28s-1 show 10d. Inside City Limits 10a. State 10c. City. Town or Location or other traumatic event, the Medical Examiner must be notified at 1 es 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colston 22/0 301 Silver Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City of wn, State 20a. Method of Disposition Department of H Important: If Its any injury or of Burial 2 ☐ Cremation 3 ☐ Removal from State 1 Aurial 2 □ Cremation 5 Other (Specify) permit. 21. Signature of Funeral Service Licensee Fun DUC Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calculac or respiratory arrest shock, or heer failure. List only one cause on lack line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Du sto (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month for 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown þ ۵ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 🔲 Yes 3 Probably 4 DUnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 certificate 1 ☐ Yes Division of Vital To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 DOA 2 ☐ ER/Outpatient funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Certification: After 1 Natural
2 Accident Injury 5 Pending 1 Yes 2 🗆 No death. investigation Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number leted cause of death (Item 23a) (Type (Plint) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 5 2004 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** July 13 2004 6:50p.M Qarni Bushra /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Nursing Home Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 71 Director ba 26 220-31-8809 32 India Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or Items 23a or 28a-f show traumatic event, the Medical Examenat must be notified at 10d. Inside City Limits 1 ☐ Yes 2€ No Directo Reisterstown MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1904 Shawan Valley Lane 21136 filed within 72 hours after death U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) 2 should be finance and Mental P Mohd Matloob Amtul Wakeel permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 1904 Shawan Valley Lane, Owais Qarni-Husband Reisterstown, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7/14/04 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signat Fineral Service Licensee 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** endo metrial concer aan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit Due to (or as a consequence of) attending physician Box 68760 certificate be Physician/Medical IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death P.O. 1 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Completed 1 🗌 Yes 2 INO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 \ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) 2 No P 1 Tes this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. he Funeral Director: After tl 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical completely (Check only one) To the within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address St. Balto Md (-Binc 6701 32. Registrar's Signature State 5 2004 Registrar

05.9

Qarni, Bushra

			For State		100	•				Mental Hy	-		
			State Registrar AMFND Decedent's Name (First,			b PER F	H_G833	3"7/26/04	D. III	2. Date of Dea		04	3. Tima of Dealth
	Physici /Medic		Alice			Ernest	ine		Rice	July	08	2004	2:45a. M
}	Examin		4a. Facility Name (If not ins						or Location of Dea	ath	4c. Cou	nty of Death	
			Mariner H 5. Social Security Number	6.S		7. Age (In yrs. I	ast hirthday)	Baltin If Under 1 Year		s. 8. Date of Birt	h	0 Righ	place (State or Foreign
	Funeral Director		217-01-755	1	□ M XIXF	85	Yrs.	Months Days			y, Year)	Cou	ntry) NC
	pu ,		Usual Residence of Deced	ent			. Town or Lo	onting.		12 0			
	Aaryla ehov	ō				1							10d. Inside City Limits 1 ✓ Yes 2 □ No
	28a-	Director	MD 10e. Street and Number	NA		Вс	altim	10f. Zip Code			10g. Citizen	of What Cou	
	h with		1718 ASHBL	RTON	Street			21	216		_	.S.A.	
	ems ?	Funerai	11. Marital Status			dent Ever in U.S	5. 13.			Specify Yes or No-		Race - Ameri Black, White	can Indian,
36	within 72 hours after death with the Maryland sne. than "natural", or Items 23a or 28a-f ehow ta Medical Exa. citrer mant be notified at	by Fu	1 ☐ Never Married 2[3 ☐ Widowed 4 ※ Div		1 ∐Yes If Yes, Giv	2 X No		1 □ Yes 2 □ X No		,	Spe	a i fa u	
Maryland 21215-0036	2 hour	edb	15. De	cedent's E		ites:	16a. Dece	dent's Usual Occu	pation		16b. Kind of	Business/Ir	lack
215	within 72 sne. than "ne	Completed	(Specify only		College (1-	4or 5+)	(Give	kind of work done DO NOT use retire	during most of w	orking			,
2	71 70	Соп	8th grade		na		C	ustodia	n	E	Balto	City	Schools
and	be of o	Be	17. Father's Name (First, M						CORNET	ame (First, Middle,	Maiden Surr	name)	
7	should be tind Mental is marked o	ဥ	Claude Clei 19a. Informant's Name/Re	*	Type Print)		19b Maili	on Address (Street		lia Harr Rumal Route Numbe		un State Zie	o Code)
Σ			Lenwood Cl				1718	ASHBUR	TON	eet, Bal			
Baltimore,	m O .		20a. Method of Disposition			20b. Pl	ace of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Locatio	n - City or T	own, State
i E	Pages ment of P ant: If ite ury or of		Magazial 2 ☐ Crem			nate			1	7/16/0	4 Ark	outus	, Md
3alt	permit. Page Department of Important: If any injury or once.		21 Signature of Funeral S	ervice Licer	1	0	22	2. Name and Address R	ess of Facility				1
			230 Rord Fotor the disease	. 10	Knic	7	1	200 Wah	ach Arre	e, Balti	more	Md	21215
			23a. Part1. Enter the diseashock, or heart failure	. List bnly	one cause on ea	ich line.	. Do not ent	ETES	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	-	a	or as a consequ	onno of).						
ı	Examiner				540 10 (Conhi	2571	VE H	ZART	FAICU	RE		
	π ≠ σ	ner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	J	Due to (or as a consequ	ence of):	2000	11001				
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	C	or as a consequ		RTEN.	51014				
8760,	cate be executed physician and the burial-transit		3 ,		. Due to (t	n as a consequ	ence or,						
687	the the	edicai			_ d								
Вох	eath certific attending p for use as	In/M	IF FEMALE: 23b. Was decedent pregna		23c. If yes, outo	come of pregnar		Ectopic pregnanc			23d. l	Date of delive	ery
-	ie deat the att hed for	Physician/Me	in the past 12 months 1 Yes 2 No	?		ant at time of de		Other (specify)	у		1	Month	Day Year
P.0	that the de led by the a detached t		9 ☐ Unknown Part II. Other significant co	nditions	ontributing to de	ath but not recu	lting in the u	ndarhina cauca a	ron in Part I	23a Did to	bacco uso co	antributo to t	he cause of death?
ds,	signe d be d	d by	Tai(ii. Other signmeant of	Jiraitions (onthouting to de	au bat not 163a	iling at the u	nderlying cause gr	veilin raiti.		es 2□No		
Records,	The law requires that ite has been signed b bage 2 should be deta	ompieted								24a. Was a	an 24	Were auto	psy findings available
Re	The lavate has page 2	omp								autop: perfor	sy med2	prior to co death? 1 Yes	mpletion of cause of
Vital		BeC	25. Was case referred to n	nedical					26. Place of De	1 ☐ Yes eath (Check only or	No No	1 1 165	2 NO
ot <	8 2 5	To	examiner? 1 🗆 Yes 2 🗗 No				ER/Outpatier	it 3 DOA		Home 5 Resid	ence 6 🗆 C	other (Specif	iy)
o uc	ing After une	iuo!		ending		f Injury n, Day Year)	28b. Time o Injury	Wo	rk?	28d. Describe h	ow injury occ	urred	
Division	tsn leat tor: ths	ficat	3 Suicide 6	nvestigation Could not b determined		of Injury - At hor	me, farm, str	M 1 C	Yes 2 □ No	28f. Location (S	treet and Nu	nber or Rum	ul Route Number,
Ω	al or A safter I Dire	Certification;	4 Homicide	, and the second	buildin	g, etc. (Specify,)	,,,		City or Tow	n, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Co	rtifying Ph	ysician: To the	best of my know	vledge, death	occurred at the ti	me, date and place	e, and due to the c	ause(s) and	manner as s	tated.
	To the H within 24 To the F complete	Aedicai	one)	1	and mann	er stated.				curred at the time, o			
	To To Con	× /	29b. Signature and title of	VY	MO	,		29c. Licens	S&459	, 2	29d. Date sign	i C	Day, Year)
1			30. Name and address of p	arean who	- /	of death floor	23a) /Tune	Print)	- 3 /- /		110	10.10	NIG MO
	H.		SYED		101	7945 +	7 /- U	RNACE	BRANC	H RD,	46-120	BUR	21060
	Sta		31. Date filed (Menth Day	XP1/1	32. Re	gistrar's Signat	ure /						
	Registr	ar		JUT	1 miles	F	والمحار	The Est					

			1 - For State Registrar			artment of Health an rtificate of Death		ene	22265
	Physici	ian	Decedent's Name (First, Middle	, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Richard	Robertson	n		07	11 2004	10:20AM
1	Examir	ner	4a. Fecility Name (If not institution,			4b. City, Town, or Location of D	eath	4c. County of Deeth	1
		12	Mercy Medical				aryland	Baltimore	City
	Funeral Director		5. Social Security Number 219–28–6269	6. Sex 7. Age (n yrs. last birthday) 70 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Aug. 14	9. Birth Cou	place (Stete or Foreign untry) MD
	and		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation			10d. Inside City Limits
	f sho	ō	MD	N/A		Baltim	ore		1XXXes 2 □ No
	288 288	rec	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Cou	intra?
	3a or	Ö	1 West Conway	St., #108		21230		US	
	hours after death with the Maryland tural; or Hems 23e or 28e-1 show al Exact withhel by notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pi	(Specify Yes or No-	14. Race - Amer	
9	after or its	Ē	1 Never Married 2 Marrie	Armed Forces?			uerto Rican, etc.)	Black, White	
03	ral', c		3 ☐ Widowed ♣️DDivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No Specify:		Specify:	white
5-0036	"natural",	Completed	15. Decedent' (Specify only highes	s Education	16a. Dece	dent's Usual Occupation kind of work done during most of	working 10	6b. Kind of Business/Ir	ndustry
2121	within ene. then	n jdu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	Working		
	ygier ygier tt.	ပ္ပ	8	0	-	Factory Worker			Facturing
<u>n</u>	be fill d oth	Be	17. Father's Name (First, Middle, L Robert T. Robe			18. Mother's Josep	Name (First, Middle, Ma		
y la	should be filed within : and Mental Hygiene. s marked other than "! umatic event, the Med	မ							
, Maryland	alth a		19a. Informant's Name/Relationsh Julia M. Davey		19b. Mailii 14	ng Address <i>(Street and Number or</i> 27 Haubert Stre	et, Baltimo	City or Town, State, Zijore MD 2123	o Code) 30
ore	permit. Pages 1 a Department of Hes Important: If item Eny injury or othe ODCE.	1 8	20a. Method of Disposition		20b. Place of Dispo	natory or other place!		Oc. Location - City or T	own, State
Baltimore	Pages nent of int: If it	h .	1 ☐ Burial Z☐Cremation 1 ☐ Donation 5 ☐ Other (Sp	3 ∐Removal from State ecify)	Bay View	Crematory July	15, 2004	Baltimore	Maryland
att	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service L	icensee Victor P. D	oda, Jr. 🕰	Name and Address of Facility			
Ω	8 3 E 2 8	0.3	Victor		u.	on East Fort Avenue	neral Home, li Baltimore M	nc. D 21230	
100			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that caused the					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	11100	Cancer				Onset and Death
	/Medical		resulting in death)	Due to (or as a c			-	-	
Mr.	Examiner		Constant for the first over the first	. Atrial	flutter				
	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	unsequence of):				
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events	c. Christian	Characti .	Blancy Dis	State .		
0,	e exe	Ä	resulting in death) Last	Due to (or as a c	onsequence of):			1	
8760,	ate b hysic the b	lical		d					
9	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	-					
Вох	tendi tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy		23d. Date of delive	•
. E	e dea he at led fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tim 9□ Unknown		Other (specify)		Month	Day Year
P.O	res that the de signed by the a l be detached (Phy	9 🗆 Unknown						
Ś	igner be d	þ	Part II. Other significant condition	is contributing to death but n	ot resulting in the ur	iderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	
orc	w require been si should b	ted					1 Yes	2 No 3 Prob	ably 4 Unknown
Records,	has b	Completed					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
		Con					performe 1 ☐ Yes 2 🖫	d? death?	
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of C	eath (Check only one)		
of \	Physician: this certificatal director, I	2	1 ☐ Yes 2 M No		2 ER/Outpatien	t 3□ DOA Other: 4□ Nursing	Home 5 Residence	ce 6 Other (Specify	y)
	ding P. After ti funera	ü	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
<u>Si</u>	Attending r death. sctor: After by the funer	ati	2 ☐ Accident investiga	ition		M 1 Yes 2 No			
Division	irsct irsct	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Injury building, etc. (3	- At home, farm, stre Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
۵	ital c rs af ral D fed ir			1				·	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medicai	Chock only 2 modical L	varianter. On the pasis of ex-	amination and/or inv	occurred at the time, date and pla estigation, in my opinion, death oc	ice, and due to the caus	se(s) and manner as st	ated.
	the thin 2 the mple	Wed		and manner stated					
	T W L	_	29b. Signature and title of certifier	D M. =	, .	29c. License number		. Date signed (Month, I	
7	1.		Jugosh	· Milarai	M.D.		4407	07,11,20	004
	B		30. Name and address of person w	. 17					
			31. Date filed (Month, Day, Year)	farai Mercy , 32. Registrar's		n Baltimore Marylan	d 21202		
rž.	Sta Registr			1004 Denes	Signature A	Ana V			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Robert Alexander Rogers July 2004 /Medical 4:10 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Prince Georges Laurel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□ F Director 71 Vrs 220-28-6102 May 28, 1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland anent of Health and Mental Hygiene.
The filem 27 is marked other then "neturel; or items 23e or 28e-1 show and the then the transfer of the treumatic event, the Muchael Exerting manage and the statement. 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Prince Georges Laure 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 9000 Briarcroft Lane 20708 Completed by Funeral United states 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: Specify: Black 3 ☐ Widowed 4 Shoivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Courier Harlow Printing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aaron F. Rogers 2 Sarah B. Bright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Starkey - Daughter 4957 Frishman Court Dale City, Virginia 22193 20b. Place of Disposition (Name of 20a, Method of Disposition Date 20c. Location - City or Town, State comptony, cromatory or other place) Christian Community Church Cemetery 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 7/16/04 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., 7250 Washington Blvd. Elkridge, Mary Gary L. Kaufman Funeral Home 7250 Washington Blvd. Elkri 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inc. Elkridge, Maryland 21075 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Perforated Viscus /Medical Due to (or as a consequence of): **Examiner** Myocardial Infarcation Sequentially list conditions Examiner if any Isacing to immedicause. Enter Underlying Cause (Disease or injury mequanda of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 2 XNo 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Tyes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 □ Yes 2 □ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053235 11,2004 30. Name an address of person ocompleted cause of death (Item 23a) (Type, Print) Darryl Hill, MD 13635 Baltimore Avenue Laurel, Maryland 20707 32. Registrur's Signatus 2004 State Registrar

			1 - For State Registrar	State of Marylan		artment of I		Mental Hy	/giene	1. 22267
	Physic		1. Decedent's Name (First, Middle, Last) John Martin	Ryan			-	2. Date of De Month		3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give stre			4b. City, Town, o	or Location of Deat	h	4c. County of [09 2 . d d / ""
	Funeral Director		5. Social Security Number 6. Sex	Qre HOS 7. Age (In yrs.	last birthday) 84 Yrs.	ROSC If Under 1 Year Months Days	of CALC If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country)
	aryland show	7	10a. State 10b. County MD Baltimore		y, Town or Lo					10d. Inside City Limits
	the Mi	Director	10e. Street and Number	= K	osedal	10f. Zip Code			10g. Citizen of Wha	1 Yes 2 No
	ath with	rai Di	1418 Spring Avenue				237		USA	. Country?
9800	be filed within 72 hours after death with the Maryland hat Hygiene. ed other than "natural" or Itams 23a or 28a-1 show event. I've Medical Exerciting must be notified at	d by Funeral	11. Marital Status 12. 1 □ Never Married 2 □ Married 3 □ Wildowed 4 □ Divorced	Was Decedent Ever in U. Armed Forces? NEW es 2 □ No If Yes, Give WWII	li li	Vas Decedent of H Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	Specify: V	American Indian, Vhite, etc. Vhite
Maryland 21215-0036	filed within 72 h Hygiene. Ither than "natu ant. I've Medical	Completed	15. Decedent's Educat (Specify only highest grade co	ompleted) College (1-4or 5+)	(Give	O NOT use retired	during most of wo	rking	Continent	
yland ;	should be filed nd Mental Hygi i marked other imatic evant.	To Be C	17. Father's Name (First, Middle, Last) John Martin Ryan				Catheri	ne Van-I		
	12 han		19a. Informant's Name/Relationship (Type, Nancy Ruscito DAUG	Print) HTER	1				er, City or Town, Stat Maryland 2	
Baltimore,	of Horitan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem		Place of Dispos emetery, crem	sition (Name of natory or other plac	се)	Date	20c. Location - City	or Town, State
altim	permit. Pag Department Important: I any njury o		'4 □ Donation 5 ☑ Other (Spenish) ← C 21. Signature → Funeral Service Licensee	mbment Gai		of Faith Name and Addre	-	4/04	Raspeburg	
ä	Der Imp		50000	NO	121	1 Chesac	o Avenue	Rosedal	edale Fune le Marylan	ral Home d 212387
	Pnysician /Medical		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each the.	816 F	the mode of dyin	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions b.	Due to (or as a consequ		RAFEREZ	a CIN	4		514.0
8760,	ate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, b	Due to (or as a consequence to (or as a consequence)	with A uence of):	Leshole	Lever's	De Kean.		io + y .
9	ate the	Medical	If FEMALE:							
.O. Box	that the death certifics ed by the attending ph detached for use as ti	Physician/M	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the un	derlying cause give	en in Part I.			e to the cause of death? Probably 4 @Unknown
Vital Records,	The law ate has b page 2 sl	e Completed	25. Was seen referred to medical					1 Yes	prior prior death 22 No 1 1 Y	
f Vit	S E	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hosp	oital: 1 ☐ Inpatient 2 ☑ I	ER/Outpatient	3□ DOA Othe		th (Check only or ome 5 - Resid	ne) dence 6 □Other (S	pecify)
Division of	ding After fune	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	yat k? Yes 2 □No	28d. Describe h	now injury occurred	
DIV	al or Attano s after death I Director: d in by the	ertif	4 Homicide determined	8e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
	To the Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	ledical C	one)	an: To the best of my know On the basis of examinat and manner stated.	wledge, death ion and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occur	and due to the or red at the time, o	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
}	Vith Com	Σ	29b. Signature and title of certifier		>	29c. License		2	29d. Date signed (Mo	
1	4X	ĺ	30. Name and address of person who compl	eted cause of death (Item		rint)	22/		7.12.	04
	Sta	te-	31. Date filed (Month, Day, Year)	222 Z 32. Registrar's Signat		0 10	ur a	10 21	122/	
	Registr	_	.111 1 5 2004	Liener	4	long				

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	- State Registrar AMEND ITEM	State of M 1 #6 PER FH	aryland G833	7 <i>6</i> 2	artment of I	lealth and Death	d Mental H	ygiene Reg. NO. () () [22268
	Physicia /Medic		1. Decedent's Name (First, Middle, I	ケレ		CH 1	ZERG		2. Date of I	4 °t1 12	aar 1 WM
	Examin		4a. Facility Name (If not institution, g NORTH QUEST HOS 5. Social Security Number 6	MOLENTER	ge (in yrs. la	est hirthday)	4b. City, Town, o	STUWN /	ND	4c. County of	IMORE
	Funeral Director	4	2/5-24-2357 Usual Residence of Decedent	1XXM 2XF	89	Yrs.	Months Days		in. (Month, I	Birth (Pay, Year) 9 19 19 19 19 19 19 19 19 19 19 19 19 1	Birthplace (State or Foreign Country) NJ
	nyland how		10a. State 10b. County		10c. City,	, Town or Lo					10d. Inside City Limits
	8e-fs	Director		TIMORE		OWING	GS MILLS			T	1 ☐ Yes 2 No
	death with the Maryland ims 23a or 28e-f show r must be rivillised at	Dire	10e. Street and Number	IDT #202			10f. Zip Code	01117		10g. Citizen of Wha	•
	Heath TIS 23	Funerai	4730 ATRIUM COU	12. Was Decedent	Ever in U.S	S. 13.	Was Decedent of I	21117 Hispanic Origin?	(Specify Yes or I		U.S.A. American Indian,
036	after or ite	by	1 Never Married Amarried 3 Widowed 4 Divorced	Armed Forces 1			f Yes, specify Cub 1 ☐ Yes 2 🙀 No	an, Mexican, Pu Specify:	erto Rican, etc.)	Specify:	White, etc. WHITE
2-0	72 ho netur	eted	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Occu kind of work done	during most of v	working	16b. Kind of Busin	ness/Industry
21215-0036	filed within Hygiene. other than " ent, the Mar	Completed	Elementary/Secondary (0-12)	5+ College (1-4or	5+)		DO NOT use retire	(d)		MEDICI	NE
Maryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "neturelt," aumatic event, the Medical Exa	To Be	17. Father's Name (First, Middle, La MOSHE	st)		ROCHI	BERG	18. Mother's N		lle, Maiden Sumame)	HOFFMAN
Mary	od 2 shoi lith and h 27 is ma r trauma		19a. Informant's Name/Relationship TOBA ROCHBERG							nber, City or Town, Sta	
re,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition			ace of Dispo	sition (Name of matory or other pla		Date	20c. Location - Cit	
m	Page nent c ant: If ury or		1 🕅 Burial 2 □ Cremation 3 1 □ Onation 5 □ Other (Spe		1		CHIZUK A	· 1	14/2004	BAL	TIMORE, MD
Baltimore,	permit. Pages 1 Department of It Important: If ite any Injury or ot		21. Signature of Funeral Service Lice	1		89		TERSTOWN		PIKESVILLE	OL LEVINSON & E, MD 21208
	Physician /Medical		23a. Part1. Enter the disease, ar co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that cause by one cause on each I	d the death.	. Do not ent	er the mode of dy	ng, such as card	liac or respiratory	arrest,	Approximate Interval Between Onset and Death
r	Examiner			Due to (or as	a consequ	ence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):					
	nd nd transit	Examiner	that initiated events	c.							<u> </u>
8760,	cate be executed physician and s the burial-transit	ai Ex	resulting in death) Last	Due to (or as	s a consequ	ence of):					
687	ficate physis the	edicai		d							
D. Box	e death certific the attending p	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3[Ectopic pregnance Other (specify)	у		23d. Date of Month	
ls, P.0	res that the designed by the a		Part II. Other significant condition	s contributing to death I	but not resu	lting in the u	nderlying cause gi	ven in Part I.		./	ute to the cause of death?
Records,	w requires been sign should be	Completed							24a. W		
Rec	e la has ye 2	mp							- au	topsy prio	
Vital	i cien : Th certificate rector, pag	0	25. Was case referred to medical					26. Place of 0	1 ☐ Yes Death (Check only		Yes 2□ No
Į Vi	di is	To B	examiner? 1 🗆 Yes 2 🗹 No	Hospital:	ient 2 🗆 E	ER/Outpatier	nt 3 DOA Ot	har		sidence 6 Other	(Specify)
n of			27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	f 28c. Inju	ry at irk?	28d. Describ	e how injury occurred	
Division		Certification:	2 Accident investigat 3 Suicide 6 Could no	t be	iva. At ha	ma (arm at		Yes 2□No	296 Logation	(Street and Number	or Rural Route Number,
ΟįΣ	spital or Attendours after death neral Director: filled in by the	ertif	4 Homicide determin	ed 289. Place of in building, e	itc. (Specify))	eet, factory, office		City or 7	own, State)	or nurar noute ryumber,
-	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physician: To the best taminer: On the basis of and manner s	of examinati	vledge, deat ion and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the	ne cause(s) and manne e, date and place, and	er as stated. If due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	ZA - 1 _	14.0		29c. Licen	se number		29d. Date signed (/	Month, Day, Year)
	- > - 0		100	1/2 min	mr))	t) 445	22	Jucy	11,2004
	le		30. Name and address of person w	completed cause of	death (Item	23a) (Турв.	Jr M/) -	NW	HC.	
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Signat	ure 4	Spork	/			

DHMH 17 Rev 1/2001

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		•	For Stete Registrar		State o	of Mary	land / Depa <i>Ce</i> a	artment of I		nd Men		ne . N2 0 ()	L	22269
	Physicia /Medic		1. Decedent's Name (F Robert J.	First, Middle, L Snade						P	Date of Death Month		Year	3. Time of Death 2:00cm M
	Examin		4a. Facility Name (If no 8474 Miramar		ive street and nu	mber)		4b. City, Town, Passa	or Location of E	Death		4c. County o		Arundel.
	Funeral Director		5. Social Security Num 220-92-1112		Sex 1√2√M 2□F		yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days		Min.	Date of Birth Month, Day, You Venber 18		Cour	elace (State or Foreign etry) 1D
	show			ob. County			c. City, Town or Lo	ecation					1	0d. Inside City Limits
	Be-f sh	Director	MD		Anne Arur	ndel			Pas ———	adena				1 ☐ Yes 2 2 € No
	3a or 2	Dire	10e. Street and Number 8474 Miran					10f. Zip Code	21122		10g	. Citizen of W		ntry? ed States
9003	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, the Medical Examinations to indiffical at	d by Funerai	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2XXNo ive		Was Decedent of If Yes, specify Cut	oan, Mexican, F	n? (Specify Puerto Rica	Yes or No- n, etc.)		, White,	en Indian, etc. hite
21215-0036	within 72 h iene. then "netu he Wedical	Completed	(Specify Elementary/Seconds 10		grade completed)	1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Langshore	during most o	of working	16	b. Kind of Bus	siness/Ind	•
Maryland 2	2 should be filed within and Mental Hygiene. is marked other then eumetic event, the Ms	To Be Co	17. Father's Name (Fin John A. Shad			-				Name (Fir a Derry	st, Middle, Ma yberry	iden Sumame	3)	
	1 and 2 should leath and Men Health and Men tem 27 is marked therefore treumetic		19a. Informant's Name Theresa J. S				8474	ng Address <i>(Stree</i> Miramar Ro				City or Town, S	State, Zip	Code)
Baltimore,	Page nent o ant: If ury or		20a. Method of Dispos 1XXXBurial 2 □ 0 14 □ Donation 5 (Cremation 3 □Other (Spec	cify)	State	Ob. Place of Dispo cometary, cre- Holy Cross	osition (Name of matory or other pla Cenetery	July	17, 20		c. Location - C altimore	-	
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230 23. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. API											
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									Approximate Interval Between Onset and Death		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list condition in any, leading to imme cause. Enter Underlyi Cause (Disease or intertat initiated events resulting in death) Las	ary .	с		insequence of):							
.O. Box 6	ires that the death certifica signed by the attending pl d be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent printhe past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?		birth 2 🗀 nant at time	Fetal death 3	□Ectopic pregnand □ Other (specify)	су			23d. Date Mon		ery Day Year
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significa	ent conditions	s contributing to o	death but no	ot resulting in the u	nderlying cause g	iven in Part I.		23e. Did tobac			ne cause of death?
of Vital Records,	The law ate has b page 2 st	Completed									24a. Was an autopsy performe 1 ☐ Yes 20	d? de	/ere auto rior to cor eath?	psy findings available inpletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:	11	0∏ 5D/0 +- ·		than		neck only one)		. (0 - :	
lof		on: To	1 Yes 2 No 27. Manne of Death 1 Natural	5 ☐ Pending	28a. Date	Inpatient of Injury oth, Day Ye	2 ER/Outpatie	" SLI DOA	4 🗆 140151		5 Residence Describe how			<u>//)</u>
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident	investigat	be 28e Plac	e of Injury - ding, etc. (S	At home, larm, st		Yes 2 No	28f. I	Location (Stree City or Town, S	et and Numbe State)	r or Rura	il Route Number,
	he Hospite n 24 hours he Funerel	edical C	29a. Certifier 1[(Check only 2[one)	Certifying Medical Ex	eminer: On the i	e best of m basis of exa nner stated.	y knowledge, deat amination and/or in	h occurred at the vestigation, in my	time, date and popinion, death	place, and o	due to the caus t the time, date	se(s) and man	ner as st	tated. the cause(s)
	To the Tour	Me	29b. Signature and titl	e of certifier	Lanza	1.0		29c. Licer	se number	5	29d	Date signed	(Month. 3, 2	Day, Year)
	10		30. Name and address	s of person wh	3 0 5	ise of death	(Item 23a) Type	Print)	Glen	Bu	mie.	, MI	۵. 2	21061
	Sta Regist		31. Date filed (Month,	Day, Year) 5 200	32.	Registrar's	Signature	Print) Pronts Pronts						:

			Sta	ite of Maryland		t of Health and M	lental Hygi	ene	
			Registrar		Certificate	e of Death	Reg	g. Nø.	22270
	Physici	an	1. Decedent's Name (First, Middle, Last)	Lum Saito			Month	Day 2004	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street		4b. City,	Town, or Location of Death	July 1	4c. County of Death	8:45 A ^M
	Examil	ler	Gilchrist Center	,		Towson		Baltimo	ore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign untry)
	Director		576-28-8957 1 ¹ M 2	73	Yrs.	Bays House IIII	JAN 25,		waii
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Mary -f sho	ţō	Maryland Baltimore		Cat	tonsville			1 ☐ Yes 2 X No
	ith tha Marylar or 28a-f show	Director	10e. Street and Number		10f. Zip		10	g. Citizen of What Cou	untry?
	th wit		10 Hay Pasture Cou	ct	2:	1228		USA	
	r dea	Funeral	An An	as Decedent Ever in U.S. med Forces?	13. Was Deced If Yes, spec	ent of Hispanic Origin? (Sports Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	If \]Yes 2∭∑No ∕es, Give ar or Dates:	1 ☐ Yes 2	No Specify:		Specify: AS	ian
Ö	hour	ed b	15. Decedent's Education		6a. Decedent's Usua	Occupation	10	6b. Kind of Business/I	ndustry
5	nin 72	plet	(Specify only highest grade com		(Give kind of wor life. DO NOT us	k done during most of work	ing	Elementary	
213	d with	Completed)+	Teacher			Education	
5	a file	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumame)	
<u> </u>	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other than "netural" or Items 23e or 28e-f show matic event, it is Maryland Example.	ပ	Henry Lum			Levine			
Marvland 21215-0036	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (Type, Pr		-	(Street and Number or Rura		-	
	Health am 2		Tsurumatsu Saito/Husb	20b. Place	of Disposition (Nam	sture Court C		LE, MD ZIZ	
altimore	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiener. Proportant: If item 27 is marked other than "natural", or Items 23e or 28e-f show amy injury or other traumatic avant, If a Maryla Example and any injury or other traumatic avant, If a Maryle Example and any once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai from State	etery, crematory or of			· ·	
į	nit. P artme ortan injur.		21. Sign (us of Ineral Server Live) see	/ metr	O Cremato	ry, Inc. 7/16 166°56Elety (0/U4 of MD T==	Baltimore	, III)
ď	Depar Impo any ir		Edward A. Gregord	nik	299 Fr	ederick Road	Baltimor	e MD 2122	28
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. [Approximate Interval Between
	Physician	8 93	Immediate Cause (Final disease or condition	Leiomyos	arcoma				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequen					
	Examiner	L	Sequentially list conditions, b.		0				
2	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen-	ce or):			3	
	executed executed in and ial-transi	xan	that initiated events C.	Due to (or as a consequen	ce of):				
245	cate be executed only sician and the burial-transit	dical E	d						
₩Q ¢		ledic							
ඩ ලයි Box 6	The law requires that the death certific to has been signed by the attending Fage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	yes, outcome of pregnancy □Live birth 2 □ Fetal de		egnancy		23d. Date of deliv	
	ne death the atte	sicis	1 Yes 2 No	Pregnant at time of death				Month	Day Year
\$ 0 d	es that the de igned by the be detachad	Phy	9 Unknown				22a Did toba	cco use contribute to	the apure of death?
7/15/64	ires tha signed	by	Part II. Other significant conditions contributions	ng to death but not resultin	g in the underlying ca	ause given in Part I.	236. Did toba		
7	w requir been si should	Completed							
7. 6	has l	mpl					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
۽ لخ	vician: The lavication in the		25. Was case referred to medical			OS Place of Peak		No 1 ☐ Yes	2□ No
3 =	Physician: this certificanal director, I	To Be	examiner?	ıl: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3 DO	26. Place of Death	me 5 Residen		MHOSPICE
7 2	g Phy er this		27. Manner of Death 28a				28d. Describe how		37/ 2011
2 10	Attanding r death. actor: After by the fune	atio	Natural 5 Pending investigation	(Month, Day roa)	M	1 ☐ Yes 2 ☐ No			
SAIR, Flowerce 7/15/64 (or Atterder de Diracto	Certification:	3 Suicide 6 Could not be determined 286	 Place of Injury - At home building, etc. (Specify) 	, farm, street, factory	, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
3	pital c urs af wal D		One Contiller	To the burn of the	dee dect				
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical				at the time, date and place, in my opinion, death occurr			
	To tha within 2 To tha comple	Mec	29b. Signature and little of certifier		290	. License number	290	d. Date signed (Month	, Day, Year)
	- s - ō		Mark	NS		N. Charles		JULY 15,	2004
	10		30. Name and address of person who complet	ed cause of death (Item 23	a) (Type, Print)		()	1,	0.34-5-
-	\		Havan J. Cho	re mo	6601	N. Charles	or Be	alteroze A	N 1504
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 1				
	Regist	rair	JUL 1 5 2004	Drewa	O dos	de			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\operatorname{July}^{\scriptscriptstyle\mathsf{Month}}$ **Physician** 14 2004 9:37 a^M Shaw, Jr. Meridith /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6011 Hunt Ridge Rd., 3111 Apt. Baltimore Baltimore Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 79 1925 Pennsylvania Director 206-12-4975 Usuel Residence of Decede 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the man, of the arth and Mental Hygiene.

ant: if item 27 is marked other then "natural", or items 23a or 28a-f show man or other traumatic event, the Medical Examinat mast be notified at 10a. State 10b. County 1 ☐ Yes 2√ No Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6011 Hunt Ridge Rd., Apt. 3111 21210 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Educator Private Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Sr. Shaw, Mary Alice ၉ Meridith Roger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Westridge Court
610 Phoenixville, PA 19460 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 Is ony injury or other tra once. Mary Jane Snell - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 7/15/2004 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral 94 21286 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 10 years rau Due to (or as a consequence of): resulting in death) /Medical Examiner te 20 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical d for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 🗆 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has r this certificate has autopsy performed? 2 No 1 TYes Vital 1 Yes 2 ₩o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 nesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Division of After thi 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 04 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 6565 N. CHARLES #203 BALT MD Z'204 HAUL N. FOSTER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 5 2004 Registrar

			1 - State Registrar Amend		of Marylar cer f h G						fental Hy	/giene Reg. No:	001	0007	^
			1. Decedent's Name (First, Midd	fle, Last)							2. Date of D	eath Day	Year	3. Time of Death	2
	Physici /Medi		Anna Katherin	e Selby							July	11	2004	1:20 P	М
-	Examir		4e. Fecility Name (If not institution	on, give street and n	umber)		4b. City,	Town, or	Location of	of Death		4c. Co	ounty of De	eth	
			Ridgeway Mano				If Under		onsvi			10.1		timore	
т	Funeral		5. Social Security Number	6. Sex 1 M 2 F	7. Age (In yrs.	last birthday) Yrs.	Months	Days	Hours	Min.	(Month, D	ey, Year)	_ 0	rthplace (Stete or Fore country)	ign
	Director		212-16-3216 Usual Residence of Decedent	A	91						oct. 1	0, 191	Z	laryland	
	land m		10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limi	its
	Mary	ţō	MD B	altimore			Δ	rbut	115					1 □ Yes 2X N	40
	128a	Director	10e. Street and Number				10f. Zip					10g. Citize	n of What C	country?	
	3a o		5634 Carville	Avenue				2	1227			United	Stat	es	
	72 hours after death with the Maryland "natural", or flems 23a or 28a-f ahow edical Exertiral must be notified at	Funerai	11. Marital Status		cedent Ever in U	J.S. 13.	Was Deced	dent of H	ispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)		Race - Am	erican Indian,	
9	or ite		1X Never Married 2 ☐ Ma		2X No]	1 ☐ Yes		Specify:		rican, etc.)		Black, Wh	ne, ec. Mite	
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5-(72 h	Completed	15. Decede (Specify only high	nt's Education est grade completed	()	(Give	dent's Usua kind of wor	rk donei d	durina mos	t of work	ing	16b. Kind	of Busines:	s/Industry	
2121	within ene. than "	d l	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT us		•			II C	0		
	Hygie Hygie other t		12 17. Father's Name (First, Middle	l ast)		1	Secre	tary		er's Nam	e (First, Middle	1		rnment	
and	ould be f Mental h arked of	Be									Unknov		,		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic avant, it a Me	우	Soloman Emman			19b. Maili	na Address	(Street			al Route Numi		own. State.	Zin Code)	-
Ma	ges 1 and 2 should be filed within 72 ho to Health and Mental hygiene. If item 27 is marked other than "natur or other traumatic avant, Its Medical						-				Arbutu				
ē,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra		Robin L. Bidd: 20a. Method of Disposition	ruger nre	20b. i	Place of Dispo	sition (Nan	ne of			Date			r Town, Stete	
OLL	Pages nent of I int: If it		1 ABurial 2 Cremation 4 Donation 5 Other		n State	udon P	•		1	7_17.	-2004	Ralt	imore	MD	
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Euneral Service								cose Fu				
B	permit. Departr Imports any inje		and I Was	W XL	10 MM	11/12/					Rd.,				
3			23a. Part1. Enter the disease,	or complications that	caused the dea			_	-					Approximate Interval Between	
-	Physician		shock, or heart failure. List tmmediate Cause (Final	st only one cause on	Elant.	1.1.	00	18-	lem	0				Onset and Death	* .
	/Medical		disease or condition resulting in death)	a	O (Ohas a consec	quence of):	+11	المجار	xerru	<u> </u>		· 		10111 600	h
	Examiner				Inein	iten								Journal	46
	4.4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec		ſ	A		1.					-
	cutec nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initieted events	c	MAH		en	de	wer	ta				Jew year	w
ó	e exe ian a urial-	EX	resulting in death) Last	Due to	o (or as a consec	quence of):									
8760,	cate be executed oblysician and the burial-transit	dica		d					<u>.</u>						
9	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	tF FEMALE:	220 If yes o	utcome of pregn	2004									
Box	attendatten	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3	Ectopic pr		,			230	d. Date of de Month	Day Year	
o.	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		304111 31	_ Other (3p	- City)							
٥	that the ded by	h h	Part II. Other significant condi	tions contributing to	death but not re-	sulting in the u	inderlying c	ause giv	en in Part I		23e. Did	tobacco use	contribute	to the cause of death?	
ds	uires that signed b	d by	Pentie ulas	n Dise	ane (ueh	WILL	eul	en		1 🗆	Yes 2□	No 3□F	robably 4 Minknov	Νħ
00	w require been si should i	lete	diagona A	holoman	Austr	iA	1000	w	m.		24a. Wa	s an	24b. Were a	utopsy findings availab	ole
Vital Records,	sician: The lav certilicate has rector, page 2	Completed	Atout the	Il a ba	1) (5	~ 101	15.	0			peri	formed?	death?		ıf
ta	iffication, pa	Be Co	25. Was case referred to medic	ri weller	J Dell	rer	Un		26 Place	of Deat	1 Tes		1 🗆 Y0	s 2 No	
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ V No	Hospital:	tnpatient 2	ER/Outpatie	nt 3 DC	Oth Oth	or .		ome 5 Res		Other (Sp.	ecify)	
of	g Phys er this eral di	n.	27. Manner of Death	28a. Dat	e of Injury onth, Day Yeer)	28b. Time of	of 2	8c. Injun	y at		28d. Describe	how injury o	occurred		
<u>io</u>	Attending F r death. ector: After by the funera	atio	1 Natural 5 Pend 2 Accident inves	ting tigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	unjury .	М		Yes 2□	No					
Division	r Atte	tific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	minod 286. Pla	ce of Injury - At h	nome, farm, st	reet, factory	, office				(Street and I	Vumber or F	Rural Route Number,	
Ö	rs after sale or sale or sale of sale	Certification:	<u> </u>												
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	icai	(Check only 2 1 Medica	ring Physician: To t at Examiner: On the	basis of examin	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ith occur	and due to the red at the time	e cause(s) ar o, date and pl	nd manner a ace, and du	is stated. e to the cause(s)	
	the the the the the the the the the the	Medical	one) 29b. Signature and title of certif	and ma	anner stated.				e number					nth, Dey, Year)	
	N Vil		Linethy 22	Va war								Tull	1 12	,2004	
	r')	n decircos	Cya wis	use of death to	m 22=) (T	Deict\	~ /-	-41			(1	111111111111111111111111111111111111111	
	•		30. Name and address of person	JA MA	, 48t		(Ing	Fen	n Pd	Su	ite 3	BiR	sell,	12004 MD2122	7
	St	ate	31. Date filed (Month, Day, Yea	r) ,32.	Registrar's Sign		,		J			J			,
	Regist		1111 1 5 20	ne be	A Company	Fi .	don u	11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 4:50 PM F-lizabeth ewel 2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Baltimore NIA 300 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🔀 F 79 -20-9121 Maryland ebruary 13,1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Yaryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Lanvale USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 No 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wate Home rade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aughte 1300 E Maryland 2/2/3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) forest Veterans Cerritary Owings Milk, Maryland 22. Name and Address of Facility CHarman 21. Signature of Funeral Service Licensee -Harn's Furer Flaves Beisterstown Road Battimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ~ 0 Due to (or as a consequence wrong ry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed res 2

Physician /Medical **Examiner**

any injury

Physician

/Medical

Examiner

10a. State

Funeral

Director

or Items 23a or 28a-f show

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

other traumatic event, the Medical Examiner must be notified at

"natural".

rthan

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, I

use as the burial-transit ρ

Be Completed by Physician/Medical Examiner

and the attending physician funeral director, page 2 should

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, After this certificate has within 24 hours after death. To the Funeral Director: A the filled in by

completely

To the !

Registrar

Medical

Certification: To

1 ☐ Yes / 2 ☐ No 27. Manner of Death 5 Pending

investigation 6 Could not be determined

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Inpatient 2 ☐ ER/Outpatient 3□ DOA

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Lesidence 6 □Other (Specify) 28c. Injury at Work?

2 No

28d. Describe how injury occurred

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License numbe

1 🗌 Yes

29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print) 30. Name 136

31. Date filed (Month, Day, Year)

25. Was case referred to medical

examiner'

2 Accident

3 Suicide

29a. Certifier

4 Homicide

JUL 1 5 2004

32. Registrar's Signature

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	4			#24a,25,26,27	,29c&30 pe	eCe.	rtificate of	Death		Reg. No.	A 6 1	22274
Physicia /Medic		1. Decedent's Name Jamira		Last) nette Shelt	ton		,		2. Date of De Month April		2004 ^{Year}	3. Time of Death 10:20 PM
Examin	_			give street and number /land Hospi			4b. City, Town, o	r Location of Death N			County of Death rince Ge	eorge's
Funeral Director		5. Social Security Nu none	umber 6	3. Sex 7. A 1 □ M 2 💢 F	ge (In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 3 32	8. Date of Bird (Month, Da April	y, Year) 24 ,	9. Birth Cou 2004 Ma	place (State or Foreign ntry) .ry1and
Maryland f show	tor	Usual Residence of 10a. State MD	10b. County	George's	10c. City, Tow Hil		est Heigh	nts				10d. Inside City Limits 1 ☐ Yes 2X No
h with the 23e or 28e	ai Director	10e. Street and Num 3362 Cur		ve #202			10f. Zip Code	20746		-	zen of What Cou SA	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Immorrant: I them 27 is marked other then "netures", or items 23e or 28e-f show eny injury or other treumatic event, it a Medical Examinating the right at 2006.	by Funerai	11. Marital Status 1 ∰ Never Marrie 3 ☐ Widowed		12. Was Deceden Armed Forces d 1 □ Yes 2 ☑ If Yes, Give Year or Dates	5?] No		Was Decedent of HIF Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: blac	etc.
in 72 hou in "neture Medical E	Completed	(Speci		Education grade completed) College (1-4or		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Ki	nd of Business/Ir	ndustry
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uld be file Nental Hy rked oth	To Be (17. Father's Name (First, Middle, La Shelto					18. Mother's Nam	isa Dor		Sumame)	
nd 2 shoutth and N 27 Is ma		19a. Informant's Na Southern		p <i>(Type, Print)</i> ind Hospita			ng Address (Street Surratts					o Code)
Pages 1 all ent of Heart If Item		20a. Method of Disp 1 Burial 2 (4 Donation	☐Çremation 3	∃ □Removal from Statectly) In Stat	e cemete	of Dispo	osition (Name of matory or other plac	ce)	Date	20c. Lo	cation - City or T	own, State
permit. Departm Importe eny inju		21. Signature	neral Sorvice Li	censes de , Dio	ector		Name and Addre Late Anat altimore,			Ba1	timore S	Street
Physician /Medical	V. Y	23a. Rant1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List oi Final	omplications that causinly one cause on each	ed the death. Do line.	ne ton			or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
be executed be executed ician and burial-transit	Examiner	Se uentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	riving injury	c	as a consequence		ere '	Svem	atu	2	7.	
ate be hysici the bu	lical		•	d								-
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		2 Fetal death at time of death		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	,			23d. Date of deliv Month	ery Day Year
uires that I	þ	Part II. Other signif	cant condition	s contributing to death	but not resulting	in the t	underlying cause gr	ren in Part I.		obacco u Yes 21	_	the cause of death?
The law requir ate has been sl page 2 should	Completed								24a. Was auto perfo 1 \(\text{Yes}		prior to co	opsy findings available ompletion of cause of
cien: cien: entific	Be	25. Was case reference examiner?	red to medical	Manitali			0#	26. Place of Dea	th (Check only o	one)		
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 Yes 2 XX 27. Manner of Death 1 XX atural			jury 28b.	Time of Injury	of 28c. Inju	y at	ome 5 Resi 28d. Describe		5 □Other (Speci y occurred	(fy)
l or Attenater deat Director:	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Place of I	Injury - At home, f etc. (Specify)	farm, st	reet, factory, office		28f. Location (City or To			al Route Number,
e Hospite 24 hours e Funerel etely filled	edicai C	29a. Certifier (Check only one)		Physician: To the be xaminer: On the basis and manner	of examination a							
To th within To th compl	Me	29b. Signature and	title of certifier	2 ol v	labe	1	29c. Licens	33268			te signed (Month,	, ,
			ress of person w	tho completed cause o	f death (Item 23a)			CLINI	ON MD	(1
Sta	ate	31. Date filed (Mon		32. Regi	strar's Signature	4	1		T T T T T T T T T T T T T T T T T T T	-		
Regist		MA	Y 2 6 21	004	was p	,/	sports					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July Pay 10 **Physician** 2004 3:00 A M Solley Kenneth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 8432 Garland Road If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye AUG. 14, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 213-22-1486 78 1925 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itam 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, It o Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Pasadena 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 8432 Garland Road 21122 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after comparation of Health and Mental Hygiene. Important: If Itam 271s merked other than "natural", or Item any injury or other traumatic event, Itambilian event. Black. White, etc. Affices: 1 No
If Yes, Give
Year or Dates: 1943-53 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 2 Specify: Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Employee Printing Plant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Roland Solley Elsie Mauch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pam Abbott / daughter 8432 Garland Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park July 13,2004 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee $\mathcal{M}\omega$ /3 $/\!\!\!\!/$ 1 Second Avenue S.W., Glen Burnie, MD 21061 (dulley Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Coronau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed signed by the attending physicien and a be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes or Attanding Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No ို 2 ER/Outpatient SEResidence 6 Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation after death. 1 □ Yes 2 □ No completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certified 29c. License number 121613

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760,

31. Date filed (Month, Day, Year) State Registrar 5 2004

Loraine M. Dailey,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

DHMH 17 Rev 1/2001

8096 Edwin Raynor Blvd., Pasadena, MD 21122

			Please	Type or Prin							-		
			1 - For State Registrar	State of Ma	-	•	rtment of F tificate of		Mental Hy	giene () Reg. No.	OOI	22276	
			Decedent's Name (First, Middle, La					Douth	2. Date of De			3. Time of Death	<u>) </u>
	Physicia /Medic			Charle	s Milt	on			July 1	2, 2	2004	4:41 P	M
}	Examin	er	4a. Facility Name (If not institution, give		Contor		_	r Location of Death			County of Deatl		
	Funeral			Sex 7. Age	(In yrs. last birtl	hday)	TOWSON If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)	Baltimo 9. Birth	place (State or Fore	ign
	Director		215-09-5916 Usual Residence of Decedent	XX ^{M 2□F} 8	9	Yrs.			8. Date of Bin (Month, Da Augus	ť 8,	1914 M	aryland	
	yland how		10a. State 10b. County		10c. City, Town							10d. Inside City Lim	
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	3a or 3	Funeral Director	10e. Street and Number 4202 Edgehill	Avenue			10f. Zip Code 2 1	211		iog. Citi	zen of What Co		
	ems 2	nera	11. Marital Status	12 Was Decedent F	ver in U.S.	13. W	as Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No)-	14. Race - Amer Black, White	ican Indian,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar then "neturel", or Items 23e or 28e-f show eumetic event, Ite Medical Evaniter must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 📆 🕱 idowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X X If Yes, Give Year or Dates:	0		□Yes XIXNo	Specify:			Specify: Wh		
<u>1</u>	in 72 h "netu	Be Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give k	ent's Usual Occup ind of work done O NOT use retired	during most of wor	king	16b, Kii	nd of Business/I		
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and	® = ≥ ≥		17. Father's Name (First, Middle, Las	₀ Gardner S	award			18. Mother's Nan	ne <i>(First, Middl</i> e icia Ci				
<u> </u>	should nd Mer marks imetic	Ţ.	19a. Informant's Name/Relationship			Mailing	Address (Street	and Number or Ru				ip Code)	
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ore	Pages 1 nent of Ho int: If iter iry or oth		20a. Method of Disposition 13☐Burial 2 ☐ Cremation 3 [Dulan	Dispos y, crem e V	ition (Name of atory or other plac Valey	^(a) 7/	Date 16/4		cation - City or 1		
altimore,	permit. Page Department Important: Il any injury o		4 ☐Donation 5 ☐ Other (Special Signature of Iner Service Lie			22.	Name and Addre	ss of Facility					_
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	Pnysician /Medical	8 9	Immediate Cause (Final disease or condition resulting in death)	a Due to (or so	17 6	(-e	ading					2 days	
	Examiner		On the House and Market	bue to (or as a	a consequence o	וכ.	/					1	
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	of):							
	oa executed cien and ourial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence o	of):							
1760,	ficate ba ex physicien s the burial			d									
x 687	eath certifica attending ph I for use as tl	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							· · · · · · · · · · · · · · · · · · ·	-
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physicien and bagge 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	/		2	23d. Date of deli Month	very Day Year	
σ.	res that t signad by be deta	by Ph	Part II. Other significant conditions	contributing to death bu	it not resulting in	the un	derlying cause giv	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?	
orde	w require been sig should b								1 🗆	Yes 2	□No 3□Pro	bably 4 Unknov	/n
Records,	e law r has be je 2 sh	Completed							24a. Was		24b. Were aut prior to c death?	opsy findings availat ompletion of cause o	le f
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Ţ	yeicie nis cert direct	To Be	examiner? 1 Yes No	Hospital: Inpatie	nt 2 ER/Out	tpatient	3□ DOA Oth	00			S □Other (Spec	fy)	
0 00	ling Pt		27. Mann of Death 5 ☐ Pending	28a. ate of Injur (Month, Day		ime of njury	28c. Injur Wor M 1	y at k? Yes 2 □ No	28d. Describe	how injury	y occurred		
Division of	l or Attending Physicien: after death. Director: After this certifica I in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be OR Bloom of Inju	ry - At home, far . (Specify)	rm, stre		195 2 NO	28f. Location (al Route Number,	-
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Sectifying P	hysician: To the best of	f my knowledge,	, death	occurred at the tir	ne, date and place	, and due to the	cause(s)	and manner as	stated.	
	To the Ho within 24 To the Fu completel	Medicai	one)	miner: On the basis of and manner sta	examination and ted.	d/or invi			rred at the time,				
	5 Wild		29b. Signature and title of certifier	a Tuy	mo		29c. Licens	054	967	29d. Daig	e signed (Month	(Lay, Tear)	
	4		30. Name and address of person who	completed cause of de	eath (Item 23a) (Турф, Т	rint)	mp 21.	204				
	Sta Registr		31. Date filed (Month, Day, Year)	- 40	r's Signature	1	vnon /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner -th Rosedal Hmov 2 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/4/1919) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 84 1 ☐ M 25 F Yrs 216 10 2190 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10h Counts 10a State ייו וייוו גי וא marked other than "naturel", or items 23a or 28a-f show or other treumatic event. It e Madical Examinat must be notified at MD Baltimore Rosedale 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7924 35th Street 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Lucas Brothers 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William A. Traumer Mary B. Benes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Geraldine Heise DAUGHTER 7924 35th Street Rosedale, Maryland 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 7/13/2004 Catonsville Md. 21228 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Faneral Service 1211 Chesaco Avenue Rosedale Maryland 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner S. uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit Cu a that initiated events the attending physician and resulting in death) Last Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown requires that the 9 Unknown sate has been signed by a page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown Completed Recor Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy performed? Yes 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 27. Mann 1 D 1 Latural of Death 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Certification: To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After 5 Pending 2 🗌 No 1 Tyes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

31. Date filed (Month, Day, Year)

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completed cause of death (Item 23a) (Typ

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 13 **Physician** Mivuki Takano July 2004 8:55 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore 13801 York Road Cockeysville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Aug 8 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 87 Yrs. Aug 1916 Director 560**-**44**-**5745 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahow the Medical Examiner must be notified at MD Baltimore Cockeysville 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road 21030 USA Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Japanese Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembler/Technician Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve Tamakichi Takano Takaye Kanchi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 91006-4322 David Sakamoto - nephew 420 Leda Lane, Arcadia, CA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 7/15/2004 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility
CAFA, Stephen D. Lohrmann, PA
18/17 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Ligensee M00986 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and wath Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Superitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Due to (or as a consequence of) 68760, physicien Physician/Medical the attending IF FFMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resultion in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was an autopsy performed Yes 2 this certificate has 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 20 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Veal 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funerel Director: After completely filled in by the funer. Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) ROADHEAD 13801 YORK RD, COCKEYSUILE, MD. 31030 SHUZARO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

unpend item#23a,27,28a-f,PER ME,G833,7/27/04eg DOS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 04471State of Maryland / Department of Health and Mental Hygiene Sharon Thompson Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** July 8, 2004 906 а SHARON THOMPSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 SC 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours ^{Year)} 1956 Days Months 1 □ M 21 F 47 Director 213-68-8297 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a, State 10b County Itams 23s or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No MD N/A BALTIMORE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2031 ST. PAUL STREET USA 14. Race - American Indian, Black, White, etc. 21218 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 5 Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 P Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MEDICAL ASSISTANT HEALTH other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hant: If itam 27 Is marked ott WALLACE BROWN ပ SHIRLEY WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBARA THOMPSON/SISTER 127 CARVER ROAD BALTIMORE, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 7-15-04 BALTIMORE, MD 0 permit. Page Department o Important: If any injury or once. METRO 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 4m mes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Methadone and Tramadol Intoxication Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the phy as IF FEMALE USB 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? 2 No 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 🕱 DOA 1 XYes 2 No Certification: To 28b. Time of Injury 8:20a 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After 1 Natural 5 Pending found 7/8/04 unknown 1 ☐ Yes 2 XNo death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide 2031 St. Paul St., Baltimore, MD found at home 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated. within 2 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certified OCME July 9, 2004 and address of person who completed cause of 30. Name 111 Penn Steet, Baltimore, Maryland 21201 Allol 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

JUL 1 5 2004

				For State Registrar		,	State c	of Mary	yland /	•			ealth a D <i>eath</i>	nd Me	ental H	ygiene Reg. Ne	004	222	80
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-)	Records, P.O. Box 60 The law requires that the death certific	ad by the at detachad fo	Physician/Medical	1 Tes 2	⊠ No		4□Preg 9□Unki		ne of death	5 [] Other (s _i	pecify)					WOILI	Duy	, 04,
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20	risi Atten	deat ctor: y the	fica	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	28e. Plac	e of Injury	/ - At home	, farm, str	eet, factor			-	8f. Location	(Street and	l Number or	Rural Route Nu	mber,
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	e Hospi	within 24 hours after death. To the Funerel Director: Atter the completely filled in by the funera	edical	29a. Certifier (Check only one)			er: On the		xamination								and m <i>a</i> nner place, and d	as stated. Le to the cause	(s)
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		4		30. Name and add	eress of person	who con	npleted cal	use of deal		a) (Type,	LU C	Rd	世	315	B	altr	nore	MD 7	1/2/0
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		Physici	ian	i. Doodding main			ogt				Month July	Day			
	E	/Medi	180	An English Name	(If not institution, give		Jg L	4h City	Town or Lo	cation of Death	July		2004 County of Deat	05:50ai	<u>n</u>
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		Funeral		5. Social Security !			e (In yrs. last birt	Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birti Co	nplace (State or Fountry)	reign
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2		des G	ner	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Dece	dent of Hisp city Cuban.	anic Origin? (Spe Mexican, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Ame Black, White		
K	9	or It	y Fu		ried 2 Marned	1 ☐ Yes 2 ☐ N If Yes, Give X	No	1 ☐ Yes		Specify:	•			ite	
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1	d 21	Hygie ther int, ii		17. Father's Name	(First, Middle, Last)					B. Mother's Name	(First, Middle				
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V	Maryland	d 2 s th an 27 is trau			olyn M. Ch		. 11			ane Syke		1960		, ,	
E	é,	1 an Heal tem 2	-	20a. Method of Dis		icck(Daugi	20b. Place of	Disposition (Na.	me of		ate		cation - City or	Town, State	
8	2	ages ont of t: If i			! ☐ Cremation 3 ☐ F 5 ☐ Other (Specify)		'	y, crematory or o nd Mem.		7/14/	04	Syk	esville	MD	
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		4		23a. Part1. Enter	the disease, or comp	lications that caused	the death. Do n	ot enter the mod	de of dying,	such as cardiac of	r respiratory a	rrest,	95-1400	Approximate	
		Discontinuo		shock, or he Immediate Cause	art failure. List only o (Final	ne cause on hach lif	10.	UVO	5 451	2				Onset and Deat	
		Physician /Medical		disease or conditi resulting in death)	ion	a	a consequence of		2 7/21)				lacy	
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	Вох	endir nuse	an/	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 ☐Ectopic p	regnancy			2	23d. Date of deli	-	
	Θ.	dea e att	sicia	in the past 1:	□No	4☐Pregnant at 9☐Unknown		5 Other (s)					Month	Day Year	
	P.O.	es that the death certificate igned by the attending phy; be detached for use as the	Physician/Medic	9 Unknow						in Breat	aa Did			the cause of death	-2
	Ś	requires that the death certificate een signed by the attending phys nould be detached for use as the	b	Part II. Other sign	ificant conditions co	intributing to death b	ut not resulting in	the underlying	ause given	in Part I.			_	bably 4. Ounkr	
	ecords,	w require been si should t	Completed								-		140 3011	Duciy 42011KI	
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	Sign	Attending r death. ector: Afte by the fune	cat	2 Accident	investigation 6 Could not be		un. Athoma fa				9f Location /	Stroot and	d Number or Pu	ral Route Number.	
	Division	or Al after d Direction by	Certification:	4 Homicide	determined	building, et	ury - At home, fa. c. (Specify)	rm, street, ractor	у, опісе		City or To			rai noute reumber,	
	_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier	1 Certifying Phy	sician: To the best	of my knowledge	, death occurred	at the time,	date and place, a	nd due to the	cause(s)	and manner as	stated.	
		he Ho in 24 he Fu pletel	Medical	(Check only one)	2 Medical Exam	iner: On the basis of and manner sta	f examination and ated.	d/or investigation	i, in my opin	ion, death occurre	at the time,	date and	place, and due	to the cause(s)	
0		To t Com	Σ	29b. Signature an	d title of certifier	110		29	c. License n	umber		29d. Date	e signed (Month	n, Day, Year)	U
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		h		1	dress of person who o	completed cause of d	leath (Item 23a) (Type, Print)		52035 Wes	mun	h.	MA	21152	
				BONU 31 Date Flori (Mrs	CHA Cities	20 7-	ar's Signature	nven	ree			, -,	1.9	-117	
		St Regist	ate trar	31. Date filed (Mo	11 1 5 2004	32. Hegistr	ai s signature	Type, Print)							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Gale Dutcher Walker JULY 14 2004 4:55p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 23 Sky Wood Court Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 1**∑**M 2□F Months Days 78 Yrs. 047-20-4378 Connecticut Director MAR 15, 1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural', or Itams 23a or 28a-f show may injury or other treumatic event, the Medical Examination to constitute the model. 10c. City, Town or Location 10d Inside City Limits 10a. State 10b Count 1 ☐ Yes 2 XNo Director Maryland (**Baltimore** Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23 Sky Wood Court 21234 USA Funeral 12. Was Decedent Ever in U.S. Agned Forces? 1 N Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 WWII 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Vivorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Dutcher Marian Tomonalis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacqueline Walker/daughter 1238 Perryman Rd. Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Metro Crematory, Inc. 7/15/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Licelesee

Thomas Gregory Cremation Society of Maryland, Inc 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malignant Prysician 9 mon ths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month ō 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page this certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours efter within 24 hours et To the Funerel D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1450 Orleans Street Baltimore Maryland 21231 K Brahmer Julie MD 31. Date filed (Month, Day, Year) JUL 1 5 2004 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DA AM Day **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** enera land 8. Date of Birth If Under 1 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) ial Security Number 2-59-329 **Funeral** Days 1 M 2 Z F Months Hours 52 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Aberdeen AVE. 21206 USA Items 23e Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian. Black, White, etc 1 Never Married 2 ☐ Married 1 Yes 2 No ö Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other than Aide 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Kedmond marked limothy Delores Holmes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's ame/Relationship (Type, Print) Important: If item 27 is any injury or other Balto. Jennean Doctard MD c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Operation 3 ☐ Removal from State Heart of Jesus Other (Specify) ^ 4 □ Donation 21. Signature of neral Socice Lice 22. Name and Address of Facility once. Balto, mo march F/H 270 Fredhilton Mass or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death disease, or com ailure. List only ef the diseas heart failure. Immediate cause (Final disease of condition **Physician** disease of condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? ō Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | the 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. ☐ Yes 2 ☐ No 24a. Was an certificate has pace 2 autopsy performed 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 **N**0 Hospital: Other: 1 🗌 Yes 1 🗂 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: Injury 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 🗆 No 2 🗋 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Mo) th. Day. Year 29b. Signature and title of sertifier 29c. License number completed cause of death (Item 23a) (Type, Print)

State Registrar Registrar's Signatu

			Please Type or Print in Black Indelible Ink. Ensu State of Maryland / Department of Health a	-	_	.
			1 - State Registrar Certificate of Death		Reg. No	22281
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Michael Willis Williams	2. Date of D Month	Day Yes	
}	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location or		4c. County of D	eath
	Funeral		5, Social Security Number 6, Sex 7, Age (In yrs, last birthday) If Under 1 Year If Under 2		irth 9.	Birthplace (State or Foreign
	Director		220-64-9196 1 XM 2 F 49 Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month, D 03/18/		ryland
	anytan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 XYes 2 □ No
	28a-f	Directo	Maryland Baltimore 10e. Street and Number 10f. Zip Code		10g. Citizen of What	
	th with	a DI	2323 W. Pennsylvania Avenue 21217		U.S.A.	,
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of Hispanic Original Hispanic	gin? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - A Black, W	merican Indian, hite, etc.
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or items 23s or 28s-f show aumsite event, the Medical Evandrer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ♣ Yes 2 ☐ No 1972 If Yes, Give Year or Dates: 1974 1 ☐ Yes 2 ☒ No Specify:		Specify:]	Black
2-0036	72 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of working	16b. Kind of Busine	ss/Industry
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	a filed al Hygie other vent, t	a a	17. Father's Name (First, Middle, Last) 18. Mother	r's Name (First, Middle		Le 200
Maryland	should ba ind Mental marked o umatic sve	To B		Belle Patt		
Mar			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)		655ma 1 5055	mi seco menomonio
more,	gas 1 and t of Haalth If item 27 or other tr		Patricia Williams / Ex-Wife 4409 LaPlata Ave 20a. Method of Disposition 2D Place of Disposition (Name of cemetery, crematory or other place)	Date Date	20c. Location - City	ryland 21211 or Town, State
Ē	Pagas ment of I ant: If its ury or o	11	'4 Donation 5 Other (Specify) Mt. Zion Cemetery 07	7/19/2004		, Maryland
Balti	permit. Page Department of Important: If eny injury or once.		21. Sign ture of Funeral Service Densee 22. Name and Address of Facility	The Derric	ck C. Jones	s F/H, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	Ave. Balt cardiac or respiratory	cimore, Man arrest,	Approximate
	Physician		Immediate Cause (Final disease or condition a. Severe Sepsis and endoca			Interval Between Onset and Death
	/Medical Examiner	-	resulting in death) Due to (or as a consequence of):	′		
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	e be executad /sician and e burial-transit	Examiner	cause. Enter Underlyin. Cause (Disease or injury that initiated events c.			
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Вох	leath certificate attending phys I for use as the	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of	
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	res that the de signed by the a I be detached t	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.			o to the cause of death? Probably 4 Winknown
Records,	w require been sig should b	Completed	Mitral value Replacement	24a. Wa:		autopsy findings available
Re	The law te has age 2 s	omp	I newly dependent diasectes mellitus	auto	opsy prior death	to completion of cause of
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of <	Physic this car	ို	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Cther: 4 ☐ Nur		sidence 6 Other (S	pecify)
on	nding th. :: After	tlon	27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 ☐ Yes 2 ☐ N		now injury occurred	
Division of	r Atter ter dea irector irector	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or own, State)	Rural Route Number,
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	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and and an analysis of examination and/or investigation, in my opinion, deat and manner stated.	h occurred at the time	, date and place, and o	due to the cause(s)
_	To t To t	Σ	29b. Signature and title of certifier 29c. License number 2 F S = 0.00		29d. Date signed (Mo	
7	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		JULY, 12	m, sur4
	\		Ranjani Ramanathan, MD sinai Hospital	of Balk	more.	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi	ar .	JUL 1 5 2004			

				For State	State of Maryland / I	Department of Health and I Certificate of Death		7 III II.	22285
		Physici	an	1. Decedent's Name (First Middle, Last)	WindER.	Certificate of Death	2. Date of Death	oay Year	3. Time of Death
		/Medio Examir	cal	4a. Facility Name Alf not institution, give-s	treet and number)	4b. City, Town or/Location of Death	DU14 6	tc. County of Deat	4 / 4 *
		Funeral		5. Social Security Number 76. Sex	7. Age fin yrs. last bit	Months Days Hours Min.	8. Date of Birth	m/ 3/1/2	holace (State or Foreigh
		Director	0	Usual Residence of Decedent	70	Yrs.	3-0-3	אויר שנ	10d. Inside City Limits
		ne Maryla 8a-f sho	Director	NO NOIA	19431	ti Moce			1 Pres 2 No
		death with the Maryland ims 23a or 28a-f show ir must be notified at	rai Dire	100 Street and Number. CEN	HEAL AVE	10f. Zigyoode 202	10g. 0	citizen of What Co	ountry?
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygjene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Evantmer must be rediffed at 2008.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Privorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
~	21215-0036	n 72 hou "natura edical E	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a	Decedent's Usual Occupation (Give kind of work done during most of wor	king 16b	Aind of Ausiness	Industry
- B		filed within 72 hours after Hygiene. other than "natural", or ite ant. The Medical Eramine		Elejneyth ry/Secondary (0-12)	College Mr. For 5+)	IECTRUAN 18-Mother's Nan	ne (Rirst, Middle, Maig	EMOK)	YEC
7	yland	should be filed with and Mental Hygiene. Is marked other thar aumatic evant. The M	To Be	William Wil	VAER	7RAI	LES 1	VILLE	R
Be	, Mary	and 2 sh ealth and n 27 is rr		ant a elati ii (7)	MER (MOTHER)	o. Malling Address (Street and Number of Pi	Pole Number City	1341to	tip Collin
J.	Baltimore,	permit. Pages 1 and 1 Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ D₂ ation 5 ☐ Other (Specify)	The state of the s	of Disp, sition (Name of,	2-14 20	cation-City or	Town te
7	Balt	permit. Pa Departmer important: any injury once.		21. Sign tu re of Funeral Service License	Dealmere	22. Name and Address of Facility 300 Ni CEUE	APAVE!	3A/6.1	We Extend
		Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death. Do e cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a consequence	ciantosis			Month
		cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	e():			
	8760,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (cr as a consequence	of):			
	Вох 68	leath certifica attending phater	n/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	ı 3 ⊟Ectopic pregnancy		23d. Date of deli	ivery
	P.O. B	at the deat by the atti- tached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death	5 Cher (specify)		Month	Day Year
7	rds, P	ires that signed d be de	by	Part II. Other significant conditions con	tributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco		the cause of death?
A.	Records,	he law requ e has been ge 2 shouk	Completed	%			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
			Be	25. Was case referred to medical examiner?	ospital:	Oth	1 ☐ Yes 2 ☑ 1 th (Check only one)		2 🗆 No
	n of	ding Physician: The Ing. The Ing. The Ing. After this certificate hat funeral director, page	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b.	Time of linjury at Work?	ome 5 Residence 28d. Describe how inj		hospice
	Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
		To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical Ce	(Check only 2 Medical Examir	ier: On the basis of examination an	e, death occurred at the time, date and place	, and due to the cause(s) and manner as	stated. to the cause(s)
		To the I within 2: To the I complet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month	
		N		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print) D47934	TU	48,2	904
		Sta	ate.	Panayous 31. Date filed (Month, Day, Year)	LedaKis 32 Registrar's Signature	301 ST Paul Pl	Baltimo	re md	. 71723
		Registi		111 1 P 200/	Por M.	Brooks			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 55 PN **Physician** WILSON JULY 2004 CLARENCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMONE SECOURS HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 4-4-1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1XM 2□F Yrs. MARYLÁND Director 219-10-7953 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 XYes 2 No MD. N/A BALTIMORE Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 1709 McKEAN AVE. 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. Int: If item 27 Is marked other than "natural", or Ital 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHEM STEEL -0-STEEL WORKER -12-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LULA LITTLE GEORGE WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 McKEAN AVE. BALTIMORE, MARYLAND 21217 ELIZABETH WILSON(WIFE) 20b, Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 N Burial 2 □ Cregnation 3 Removal from State ō permit. Page Department o Important: If any Injury or once. ARBUTUS MEMORIAL PARK 7-17-2004 BALTIMORE, MARYLAND * 4 Donation 5 Other (Specify) JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fineral Service Licersee 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 7 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease Toondition resulting in death) PNEWMONIA Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 onknown DEMENTIA Completed DECUBITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DEHYDRATION 1 Yes 2 - No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BATIMONE, MD BON SECOURS MILLEN TAOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1111 1 5 2004

CPM 4 - 04337Amend Trem #1 per me C835 9/14/04 tas State of Maryland /->
State of Maryland /->
State of Maryland /->
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Banzeol Bazmore 1 - State Registrar AMEND ITEM #5 PER FH G833 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vonzeol Earl Bazemore II Month July **Physician** 02, 2004 23:22 VONZEOL EARL BAZEMORE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 217-02-3474 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☐M 2□ F Months Yrs. 33 JUN.1,1971 Director MARYLAND 217 12 3474 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ust be notified at MD. N?A BALTIMORE Director 1X Yes 2 □ No 28a-f 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ö 3308 DORITHAN ROAD 21215 Itams 23a U.S. Α. death Completed by Funeral $_{
m OF}$ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced "natural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) EMPLOYED al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME REPAIRS UNKNOWN UNKNOWN 7 Is markad othe traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental H VANZEOL BAZEMORE AUDREY BAKER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 5 19a. Informant's Name/Relationship (Type, Print) f Health AUDREY BAKER (MOTHER) 3308 DORITHAN ROAD BALTIMORE, MARYLAND othar 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. MT TON CEMETERY 7/9/04 W Burial 2 ☐ Cremation 3 ☐ Removal from State LANSDOWNE, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LEWIS 22. Name and Address of Facility
LEWIS T. GWYNN FUNERAL HOME 21215-6393 T. GWYNN Inn 4517 PARK HEIGHTS **AVENUE** BALTO . MD 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physiclan/Medical use as the Box IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 Probably 4 □Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 No Yes 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: XXYes 2□ No Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) Certification: To 1 🗌 Inpatient 2X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Pay Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 225 1 Natural 5 Pending 24 1 Yes 2 No death. investigation 2 Accident after death the 6 Could not be determined 3 Suicide Place of Injury - At hon building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Boute Number, filled in by 4 Comicide City or Tov State) せど 0 0 within 24 hours a

To tha Funaral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 X Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature A

State Registrar

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1 6 2004

31. Date filed (Month, Day, Year)

completed cause of do

32. Registrar's Signature

DHMH 17 Rev 1/2001

ath (Item 23a) (Type, Print)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

Year

July 03, 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 15 2004 ear **Physician** Virginia R. Brooks 4:43am /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riverview Nursing Center Essex Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🐼 F 218-05-5576 86 Yrs. Director Oct.8 1917 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at MD Director Baltimore 1 ☐ Yes 2 X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 629 New Jersey Ave. 21221 USA death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 te marked other than "netural", or iter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No SpecifyWhite þ 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leonard Long Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Murray 629 New Jersey Ave. Baltimore MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl
once. oAkLawnCemetery 1 Burial 2 Cremation 3 Removal from State 7/19/04 Baltimore MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee. LLRI 300 Mace Ave. Baltimore MD 23a. Pert1. Enter the disease, or empirications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3-4 hoko Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) pulation **Physician** /Medical **Examiner** duance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 210 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☑ No 3□ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 Tes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. BASTERN BLVD. MD -2122 WASERM MALIKA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 2237 own 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Baltimore of NA University 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 05.13.1928 **Funeral** Days Hours 1 MM 2 □ F 218.26.494 76 MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23s or 28s-1 shov any injury or other traumatic event, the Medical Examiner in that by Invitinal at Director MO HOWARD 1 ☐ Yes 2 No COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? FAULKNER 10706 RIDGE ROAD 21044 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE TEACHER COLLEGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EARL W. BROWN, CLEOPATRA FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY 10706 FAULKNER BROWN RIDGE COLUMBIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE 07-20-04 CROWNSVILLE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
BALTO. MD 21229 21. Signature of Funeral Service License 9 5151 BAHO. NATE PIKE, BALTO, MD 23a. Part 1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of) **Examiner** pertension Sequentially list conditions, if any local sequentially list number as cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 5 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cancer 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Matural 5 Pending 2 🗆 No 2 Accident investigation 1 TYes Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funeral Direct letely filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dr. Brian Salter MO 7/13/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 21210 Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 1	5/1	ŀ	1 - For State Registrar	State of Mary	•	artment of F		Re	eg. No. 0	04	22290
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last JOHN VINCENT BATE 4a. Facility Name (If not institution, give Franklin Square	Street and number)		4b. City, Town, or Rosed	r Location of Death		2, 200 4c. Count	Year 4 y of Death	3. Time of Death 1018 A M
	Funeral Director		5. Social Security Number 219~40~3042 15 Usual Residence of Decedent	7. Age (III XIM 2 F 61	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 2,	Year) 1943	9. Birtho Cour Mar	place (State or Foreign ntry) Cyland
	r 28e-1 ehow	rector	10a. State 10b. County Maryland Baltimo:	1	oc. City, Town or Lo	Baltimo:	re County		0g. Citizen of		10d. Inside City Limits 1 ☐ Yes ※ No
21215-0036	n 72 hours after death with the Maryland "natural", or items 23s or 28e-f ehow edicel Examinat must be mutilled at	Be Completed by Funeral Director	8617 Castlemill C 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grade)	12. Was Decedent Eve Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	16a, Dece	Was Decedent of H If Yes, specify Cuba I Yes XX No dent's Usual Occup kind of work done to NOT use retired	Specify:			ce - Americ Ick, White, fy: Wh	etc. nite
Maryland 212	should be filed within 'and Mental Hygiene,' s marked other than "umatic event, I'm Mat	To Be Comp	Elementary/Secondary (0·12) 12 yrs. 17. Father's Name (First, Middle, Last) John Woodrow Bate	College (1-4or 5+) N/A	me.	Car Sale	S 18. Mother's Nam		Maiden Sumai	me)	odge~Chrysl
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. importent: if item 27 is marked other then "natural", or items 23s or 28e-1 ehow any injury or other treumatic event, the Medical Examination instituted at once.		19a. Informant's Name/Relationship (T. William P. Bates 20a. Method of Disposition 1 □ Burial ▼ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	(Brother) Removal from State	9445 20b. Place of Dispo camatery, crei Metro Cre	ematory or other place ematory , I 2. Name and Addres assahn Fi	St. Rich	nland, Mi Date 2 -2004 E	. 4908 20c. Location Baltimo	33 - City or To ore, M	own, State
The second	Pnysician /Medical Examiner	er	23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause (Enter Underlying Cause, Cisease or injury)	ilications that caused the one cause on each line. a	e death. Do not ent	401 Bela: er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
38760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):						
P.O. Box 6	that the death certific led by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown]Fetal death 3 □	Ectopic pregnancy Other (specify)	,			ate of delive onth	ery Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		s 2 No	tribute to th	ne cause of death?
Vital Rec	The ate h	e Completed	25. Was case referred to medical				26 Place of Dog	24a. Was ar autopsy perform 1 Yes 2	ned?	prior to cor death?	psy findings available mpletion of cause of
Division of Vi	ding Phys	Certification; To B	examiner? 123 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury	- At home, farm, str	28c. Injury Worl M 1	er: 4 □ Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 □Oth w injury occur reet and Numb	red	
Div	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Certi	4 ☐ nomicide 29a. Certifier 1 ☐ Certifying Phy	building, etc. (S sician: To the best of m iner: On the basis of ex-	Specify) ny knowledge, deatleamination and/or in	occurred at the time	ne, date and place, pinion, death occur	City or Town	, State)	anner as st	tated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier 30. Hame and address of person who c	and manner stated	L MD		e number		July 13		
	Sta Registr		Patricia Aron 31. Date filed (Month, Day, Year)	32. Registrar's	KMP 11	1 Penn St	reet, Ba	ltimore,	Maryla	and 2	1201

ORIGINAL

		1 - State Registrar	e of Maryland / D		rtment of H		d Mental H	ygien Reg. N	~ ~	1 000		
Physic /Medi		1. Decedent's Name (First, Middle, Last) Carol L. Beittel				•	2. Date of I Month July	Death	004 Ye	6:30 AM M		
Exami		4a. Facility Name (If not institution, give street an Gilchrist Hospice	d number)		4b. City, Town, or Balti	more		44	c. County of D	Peath		
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒	7. Age (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. Apr 2	Birth Day, Year B, 19	9. 43 M	Birthplace (State or Foreign Country) [aryland		
Maryland f ehow	o	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town		imore					10d. Inside City Limits 11℃ Yes 2 □ No		
or 28a-	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What	Country?		
ms 238	Funerai	2900 Cresmont Avenue 11. Marital Status 12. Was	Decedent Ever in U.S.	13. W	/as Decedent of His Yes, specify Cubar		(Specify Yes or I	No-		merican Indian,		
ours after rel', or Iter	by	1 ☐ Never Married 2 ☒ Married 1 ☐ \\	d Forces? 'es 2 XNo s, Give or Dates:		Yes, specify Cubar ☐ Yes 2 No	n, Mexican, Pu Specify:	erto Rican, etc.)		Black, W Specify:	/hite, etc. white		
is 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 le marked other then "neturel", or Items 23a or 28a-f ehow other traumatic event. If a Medical Exentiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12 Colle 4		(Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired	uning most of v	working		Kind of Busine	•		
filed w Hygier other th	Be Cor	1.Z 4 17. Father's Name (First, Middle, Last)		1	teacher	18. Mother's N	lame (First, Midd		lucation Sumame)	on		
ould be Menta harked	To B	William Thomas Coone					olyn Eli					
and 2 sh ealth and m 27 le m		19a. Informant's Name/Relationship (Type, Print Cleon Beittel/spouse	290	00 0	Address (Street a							
Page nent o nnt: If		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 1 1 ☑ Donation 5 ☐ Other (Specify)	camatan	Dispos y, crem	ition (Name of atory or other place	e)	Date	20c. L	ocation - City	or Town, State		
permit. Departn Importe eny inju		21. Si maters of Funeral Service Licensee	Cor	St	Name and Addres Ite Anato Ltimore,	my Boar	rd 655 W 201	. Bal	Ltimore	Street		
Physician /Medical Examiner	ير		e to (or as a consequence of	of):		g, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death		
To the Hospitel or Attending Phyeicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Du d	e to (or as a consequence o									
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The law requir ate has been si page 2 should	Completed						24a. Wa aut per 1 □ Yes	is an opsy formed?	prior			
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the Hosp hin 24 ho the Fune npletely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On I and 29b. Signature and title of certifier	he basis of examination and manner stated.	d/or inve	estigation, in my op	inion, death oc	curred at the time	, date an	d place, and c	due to the cause(s)		
To To	-	MArthuy l	ly, ms		025	205		Jul	y 4 -	onth, Day, Year) 2008 21205		
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Sta Regist	ate rar	31. Date filed (Month, Day, Yeár) JUL 1 6 2004	32. Registrar's Signature	A	souls							

unpend item#23a,27,PER ME,G833,7/27/04eg Mark W. Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 04158State of Maryland / Department of Health and Mental Hygiene AE 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) June **Physician** 2004° Mark W. Brown 11:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 33043 Old Ocean City Road Parsonsburg Wicomico 5. Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 25, 1952 Funeral Birthplace (State or Foreign Country) Months Days Hours Min. 1**X** M 2□ F 52 Yrs. Director Mary1and Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show ir Itams 23s or 28a-f shov riner must be notified at MD Wicomico Parsonsburg Director 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other traumest." 33043 Old Ocean City Road 21849 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) unk College (1-4or 5+) unk laborer landfill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be Gorman Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Julia Banks/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stale · 4 □Donation 5 NOther (Specify) in state State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Signature of Euneral Service Ronald man Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Physician/Medical Examiner cause Enter Underlying Cause (Disease or injury Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, pe 3 ☐ Probably 4 ☐Unknown 2 No 1 Yes tuneral director, page 2 should Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of 2 1 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence $_{6\,\square}$ Other (Specify) at SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tyres 2 □ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) OCME June 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOGAN 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souls JUL 1 6 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10° **Physician** JULY 2004 2040 Josephine M. Bennett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr 15, 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F 69 ĩ 9̈́35 Director 217-32-7315 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturalt, or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County **Allegany** MD Cumberland 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39 Browning Street #A 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Larry Ierace Leota Dye ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Keller/daughter 105 Cornerstone Lane Myrtle Beach, SC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Squature of Euneral Service Licenses State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE LUNG DISEASE END STAGE 10 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dee to for as a consequence of The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 No 3 Probably 4 Unknown SUBARACHNOID HEMORRHAGE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an INTRAVENTRICULAR HEMORRHAGE has page 2 autopsy performed? cate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 📈 Inpatient this 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours a To tha Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 86 MD (OBU anera, Wand 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

DR. ROBUSTIANO BARRERA

JUL 1 6 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

500 MEMORIAL AVENUE CUMBERLAND, MARYLAND 21502

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D			For State Registrar	State of N	Maryland / De <i>C</i>	partment o e <i>rtificate d</i>		nd Mental H	lygiene Reg. Na	2001.	22294	
			1. Decedent's Name (First, Middle,	Last)				2. Date of Month	Death		3. Time of Death	_
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1	Examir		4a. Facility Name (If not institution,	give street and numbe	r)	4b. City, Tow	n, or Location of	f Death	4c	County of Death		
			JOHNS HOPKINS H			BALTI						
	Funeral			5. Sex 7. A 1 ☐ M 2 🔀 F	Age (In yrs. last birthda Yrs.		ear If Under 2 ays Hours	Min. (Month,	Day, Year)	Cot	nplace (State or Foreign untry) yland	7
	Director		220-51-9285 Usual Residence of Decedent		6 113.			May	5 199	8 Mar	yland	
	rland ow		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	_
	r 28a-f show	ţō	MD Balti	more		Ess	ex				1 □ Yes 2€ No)
	ith the	Director	10e. Street and Number			10f. Zip Coo	de		10g. Cit	îzen of What Co	untry?	_
	death with the Maryland ms 23e or 28a-1 show I must be notified at		531 N MArly	n Ave.			21221		US	SA		
		Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 1:	3. Was Decedent	of Hispanic Orig	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White		_
36	or it	by Fu	1¥ Never Married 2 Marrie	d 1 ☐ Yes 2 ☐ If Yes, Give	XNo	1 ☐ Yes 2 🔀				SpecifyWhi		
Ö	within 72 hours after ene. then "natural", or ite		3 Widowed 4 Divorced	Year or Dates					1 101 10			
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p	filled I Hyg othe	Be C	17. Father's Name (First, Middle, L.	ast)			18. Mother	's Name (First, Mid				_
lar	ald be denta rked tic ev	To B	Paul J. Col	eman			Trac	cey But	cher			
Maryland 21215-0036	short short	-	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	iling Address (Str	reet and Number	or Rural Route Nu	mber, City o	r Town, State, Zi	ip Code)	
	and 2 salth n 27 i		Paul Coleman	/ father	53	11 N MA:	rlyn A	ve. Balt	imor	e MD		
ore	ges 1 and 2 should be filed w t of Health and Mental Hygler If item 27 is marked other th or other traumatic event, the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	₹ Pemoval from State	cemetery, c	position (Name of rematory or other	place)	Date		cation - City or T		
Ĕ			`4 □Donation 5 □Other (Spe		° Colemar	Family	Cemete	ry7/19/0)4 Am	herst	VA	
Baltimore,	permit. Par Departmen Importent: any injury once.		21. Signature of Funeral Service Li	censee Luca	nelly	22. Name <i>a</i> nd Ad		Connell Ave. Ba			meofEssex	ζ
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×	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy					23d. Date of deliv		
Вох	atter after I for L	ciar	in the past 12 months?	1 ☐ Live birth	2 Fetal death	☐Ectopic pregna			4	Month	Day Year	
0	tt the de by the d	Jysi	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9□ Unknown			/					
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rds	quire in sig uld b	pa						1	∐Yes 2∫	No 3□Prol	babiy 4 □Unknown	
Records,	> 14 (/)	Completed						24a. W		24b. Were auto	opsy findings available	-
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of Vital	iclan: Th certificate ector, pag	a	25. Was case referred to medical				26. Place o	of Death (Check on		(A) Tes	2 No	
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0 (27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury 28b. Time ay Year) Injury		njury at Work?	28d. Describ	e how injur	y occurred	\$	
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investiga	tion July 13	2004 4:04		☐Yes 2 🕱 No	o pedesmi	an Str	uch by ve	hile	
Σį	of or Attendate after death Director: /	Ħ	3 Suicide 6 Could no 4 Homicide determin	ad 280. Place of I	njury - At home, farm, atc. (Specify)	street, factory, offic	се	28f. Location	(Street and	d Number or Run	al Route Number,	ī
Q	itel o				alle	1		West of	317 Cap	ital Court	OWNE, HID	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the best taminer: On the basis and manner s	of examination and/or	ath occurred at the investigation, in m	e time, date and ny opinion, death	place, and due to the control of the	ne cause(s) e, date and	and manner as s place, and due to	stated. o the cause(s)	
	To t To t	Ž	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date	a signed (Month,	Day, Year)	_
	_		Jasta?	Treense	NID	0	.C.M.E.		JULY	14, 200	14	
	9		30. Name and address of person w		geath (Item 23a) (Typ					, 200		Ì
				renhera,	Mill	111 Pen	n Stree	t, Balt _{im}	nra i	Maryland	1-21201	
	Sta	7.7	31. Date filed (Month, Day, Year)	32. Pegis	trar's Signature	books			OTC' I	ATATIO	L ZTZOT	
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Year Physician nstantine 04 2 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Baltimore
If Under 24 Hrs. 8. De enter TIMORE romine 7. Age (In yrs. last birthdey) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Days 1□M 2 F Usual Residence of Decedent Director 1. Carolina 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MI Baltimore Funeral Director ItIMOR 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21 12. Was Decedent Ever in U,S.
Armed Force 17
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify. Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Marc momas eeves 19b. Mailing Address (Street and Number of Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MO 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) BAUTI MORE 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Shore VA Cemetery 7-23-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BALTIMORE, MD 21234. Do not enter the mode of dying, such as cardiac or respiratory arrest, 8800 HARFORD RD Approximate Interval Between Onset and Death 23a. Part1. Enter the diseese, or shock, or heart failure. List death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 31/ Nº 1 ☐ Yes 🗡 ☐ No 1 _ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this within 24 hours effer death.

To the Funeral Director: After thi completely filled in by the funerel 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No investigetion 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name end address of person who gompleted cause of death (Item 23a) (Type, Print) balron mp2/237 Bud 5601 Loch Kaun 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CATHERINE DEARING EDMONIA AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA JOSEPH RYCHIE HOSPICE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-03-192 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗗 F Months Days Hours Min. 220.22.3951 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar man be notified at MD NIA 1 XYes 2 □ No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROAD 4268 ROKEBY 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than *r filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC NA 8TH GRADE 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT COLDWELL EDMONIA CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar important: If item 27 Is any injury or other trau 4268 ROKEBY RD. BALTO. MO EDGAR DEARING 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST * 4 ☐ Donation 5 ☐ Other (Specify) 01-21-04 OWINGS MILLS. 21. Signature of Funeral Service License 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5161 BALTO. NATIL PIKE, BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Obath Immediate Cause (Final disease or condition resulting in death) Physician me /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unseaso or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an EDMONIA has autopsy certificate Yes 2 🗆 Ng Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence Χo 1 Yes 2 6 dther (Specify) 2 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital within 24 hours a To the Funeral C completely filled in

29b. Signature and title d

State Registra

0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 Ber A

> 31. Date filed (Month, Day, Year) JUL 1 6 2004

32. Registrar's Signature

2

Hamill

29¢. License number

29d. Date signed (Month, Day, Year)

2/7/8

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Dicks William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Baltimore Hogoita If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex 11 M 2 F 5. Social Security Number Days **Funeral** Hours Months 61 259-66-2601 12-12-Ga. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar roust by notified at ¥□Yes 2□No Baltimore Funeral Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 2724 Maryland Avenue Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 245 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) 6 yrs. Teacher J.H.H. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dicks, Sr. Carrie Berry Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2813 Oakland Ave., Augusta, Ga. Sister Dorothy Dicks 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Grove Cem. 7-17-04 Augusta, Ga. 4 □ Donation 5 □ Other (Specify) Baltimore, Md. 21202 22. Name and Address of Facility ature of Funeral Service Licensee 1101 E. North Ave. March F.H. East Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Myo condial Immediate Cause (Final Probable Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed 4theru sc lerusis resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 No 3 Probably 4 Monknown Cell Ly-phona runia - PCP 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No certificate Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₽ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Direc 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20058570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21239 Lock Roven Baker MD 5601 Terrance 32. Registrar's Signature 31. Date liled (Month, Day, Year) Registrar 2004

DHMH 17 Rev 1/2001

State Registrar

JUL 1 6 2004

31. Date filed (Month, Day, Year)

Ben & Sperk

2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			For Stete Registrar	State o		/ Depa	artment of Hertificate of L	ealth and M	lental Hygie	_	22299
	0		1. Decedent's Name (First, Middle	Last)	_				2. Date of Death		3. Time of Death
	Physicia /Medic		Duane C. Doct	ry					June 25	Day Ye 2004	3:45 PM M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, or	Location of Death		4c. County of D	
		ш	Joseph Richey	Hospice			Balt:	imore			
	Funeral		5. Social Security Numberunk	6.Sex 1 💢 M 2 🗆 F	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9.	Birthplace (State or Foreign Country)
	Director			MW ZU	56	Yrs.			June 17,		Maryland
and	* -	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation				10d. Inside City Limits
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the	28a-	rec	10e. Street and Number	-			10f. Zip Code		100	. Citizen of Whal	Country?
with	3a or	٥	828 N. Eutaw S	treet			2120	1			•
death	ms 2	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cuban		ecify Yes or No-	USA 14. Race - A	Manerican Indian,
6 after	or fo	교	1 X Never Married 2 ☐ Marrie	Armed Fo 1 ☐ Yes If Yes, Gi		1			Rican, etc.)		/hite, etc.
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72 viđi	han.	mpi	Elementary/Secondary (0-12)	College (life. L	OO NOT use retired)	-			
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and	ed of	Be	Joseph Doc						e (First, Middle, Mai .ta Trotte		
ry is	d Me mark matic	၉	19a. Informant's Name/Relationsh			10b Mailia	g Address (Street ar				- 7.0 //
Ma d 2 s	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Micdigal Examiting instituation once.		Juanita Doctry/				Mt. Royal				
. 1 a	Heal tem 2		20a. Method of Disposition	mother	20b. Plac	e of Dispo	sition (Name of			. Location - City	
noi ages	t: If if		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🕅 Other (Sp	Removal from	State cem	etery, cren	natory or other place)	200	a coodiion ony	or rown, oraco
= =	artme ortan injur		21. Signature of Funeral Serviced		1	22	Name and Address	of Facility -	1 (7		
Ba Pern	Depa Impo any ii	ļ	Ronald S	WARDE!	rector					Baltimo	ore Street
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	emplications that	aused the death.		Baltimore or the mode of dying.				Approximate
- 33	1.7		shopk, or heart failure. List of Immediate Cause (Final						, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	rysician Medical	ĺ	disease or condition resulting in death)		(or as a consequer		uedenun	1			months
< E	xaminer			Due to	(or as a consequer	100 017.					
2		je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to	(or as a consequer	nce of):					
S bell	hysician and the burial-transit	Examine	Cause (Disease or injury that initiated events	С.							
0 %	an an rial-tr	Exa	resulting in death) Last		(or as a consequen	nce of):					
υ ψ 3: ψς 3x 68760, certificate be executed	he bu	cai		d.							
4 68 es	as th		In the second of								
XO XO	attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy pirth 2 Petal de		Ectopic pregnancy			23d. Date of	delivery
Z B	the att	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of deatl		Other (specify)			Month	Day Year
P.O.	ed by the detached	Ž,	9 🗌 Unknown								
Ø ± 8	igne be d	ρ	Part II. Other significant condition	s contributing to d	eath but not resultir	ng in the un	derlying cause giver	in Part I.			to the cause of death?
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law e	hasb ge 2 sh	Completed							24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
Z H ef	page	Con							performed	? death	?
Doct of Vital	₩ 5	Be	25. Was case referred to medical examiner?					26. Place of Death			- 1
Of V	등 글	٥	1 ☐ Yes 2 No		Inpatient 2□ER		: 3☐ DOA Other	4 Nursing Hor	ne 5 🗌 Residence	6 Other (S	oecity) tespice
, c	fter	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury 28 th, Day Year)	lb. Time of Injury	28c. Injury a Work?		8d. Describe how in	njury occurred	
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WAN L Division	orter or Direction by	Ē	4 Homicide determin	ed 286. Place	of Injury - At home ing, etc. (Specify)	, farm, stre	et, factory, office	2	28f. Location (Street City or Town, St	t and Number or tate)	Rural Route Number,
X lesi	eral F	Ö	29a. Certifying	Dhysisians To st	1 1 1 1 1 1 1 1	d== 1 d		<u> </u>			
Divant Division the Hospital or Attending	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	(Check only 2 Medicel E	reminer: On the b	asis of examination ner stated.	and/or inv	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	and due to the cause and at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
o the	o the	₩ Me	29b. Signature and title of certifier				29c. License i		29d.	Date signed (Mo	nth, Day, Year)
	> 10		> SITED AN	ſ\			02	4171	1	110	mil
			30. Name and address of person w	ho completed caus	se of death (Item 23	Ba) (Tyne F	Print)	((10	1	wiyo, 2	wy
			ETSO MI	10.	1 11	spice	838 N E	Tutau G	t a it	wwo M	1D 21201
	Stat	e	31. Date filed (Month, Day, Year)		egistrar's Signature		1	William D	Salti	A-01-6 1.	
	Registra	ar	JUL 1 6 2	004 /	epera	B	sports	1			

CPM 04-04534 PRENTICE DRUMMOND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	เท		Ast) Prentice	Drumn	nond		2. Date of De Month	Day	Year	3. Time of Death
/Medica		4a. Facility Name (If not institution, g		Diami	4b. City, Town, or I	ocation of Death	July	10,	2004	16:43
LXaiiiii	G1	815 West Sarato		partment				,,		
Funeral Director		219-80-7331	Sex 7. Age	(In yrs. last birthe	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 26	th 19, Year) , 1965	9. Birthpla Count Wa l	ace (State or Fore Vand
A 19		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10	d. Inside City Lim
28a-f show	ector		I/A			more				X 1 Yes 2 1
23a or 3	Funeral Director	10e. Street and Number 815 W. Saratoga Street			10f. Zip Code	21201			Vhat Count U.S.A.	ry?
- 3	þ	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ever in U.S.	13. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No		cify Yes or No lican, etc.)	Specify	e - America k, White, e	tc.
han "naturel",	Be Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+	(0	ecedent's Usual Occupat Give kind of work done du fe. DD NDT use retired) Un	ring most of workin	g	16b. Kind of Bu	usiness/Indu Unk.	ustry
al Hygiene. other than '	ပိ	17. Father's Name (First, Middle, La.	st)			18. Mother's Name	/Eirst Middle	Maiden Sumam	21	
and Mental Fish marked of	o Be	, , ,	Drummond			io. Mother's Name		y Stephens	Θ)	
mark matir	၉	19a. Informant's Name/Relationship		19b. N	lailing Address (Street ar	nd Number or Rural	Route Numb	er. City or Town	State Zin (Code)
27 is	1	Lacy Drummond Moth			815 W. Saratoga					
nt: If item 27 iry or other tre		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of D	isposition (Name of crematory or other place) Vochelle Cem.	Da	r/16/04	20c. Location - Baltim	city or Tow	
Department of P Important: If ite any injury or ot once.		21. Signature of Fune All Service Lic			22. Name and Address Estep Bro	of Facility thers Funeral aw Place Balt	Home P.	A. 21217		
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Baltimore, Maryland 21215-0036

of Vital Records, P.O. Box 68760,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VINCENT FITZGIBBONS JR. July 2004 10:54 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City University Hospital n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 47 215-74-9682 Yrs. Director March 16 1957 Mary1and Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show The Medical Examiner must be notified at Md. n/a Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Covington Street 21230 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Never Married 2 Married 5 1 ☐ Yes 2 🗓 No Specify: White Specify: 3 ☐ Widowed 4 N Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Drywall Finisher Construction 11 Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe Celeste J. Wroten J. Fitzgibbons Sr. Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Upshire Drive, Inwood, West Virginia 25428 (Mother) Celeste J. Markle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery | 07/17/2004 | Baltimore, Md. permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Id. 23a. P.M.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only on cause on each line. 21122 Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Stah Wound disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death signed by the aid 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 XNo 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[\subseteq \text{No} \] 24a. Was an page 2 s has autopsy performed? Yes ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1√ Yes 2 No ij P 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of 28a. Date of Injury (Month, Qay Year) 27. Manner of Death 28d. Describe how injury occurred Medical Certification; Hospital or Attending 5 Pending investigation Found 1 Natural Subject Stabbed

281. Location (Street and Number or Ryral Route Number,
City or Town, State) 519 Gittins tvenue
Baltinore HD 10:00 M Found 7/13/04 1 ☐ Yes 2 🗖 No hours after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide .⊆ Outside within 24 hours a To the Funeral I filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 OCME July 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAR 111 Penn Street, Baltimore, Maryland 21201 LAN ind

State Registrar

DHMH 17 Rev 1/2001

JUL 1 6 2004

31. Date filed (Month, Day, Year)

32, Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Morkh 2:50PM **Physician** ROBERT Le ROY GREGG /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner N/A cenera Maryland timo 5. Social Security Number 7. Age (In yrs. last birthday) Unde If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 12,1952 9. Birthplece (State or Foreign 6. Sex **Funeral** Months 1 M 2 □ F Days Hours MARYLAND 52 218 52 2683 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show ir than "natural", or Items 23a or 28a-f shov The Medical Examinar must be notified at OWINGS MILLS, MARYLAND BALTIMORE MD. 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 55 FEATHERBED LANE 21117 U.S. OF A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AUTO SHOP UNKNOWN MECHANIC othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be and Mental WILLIAM MELVIN GREGG (DECEASED) DORA HOWARD GREGG (DECEASED) SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) -Department of Health a Important: If item 27 Is any injury or other trai MARY PATRICIA GREGG-JENKINS 1634 PENTWOOD ROAD BALTIMORE, MD. 21239 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GOUGH CHURCH CEM.7/14/04 COCKEYSVILLE, MD. * 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Libensee 22. Name and Address of Facility once LEWIS T. GWYNN FUNERAL HOME 21215-6393 LEWIS Τ. **GWYNN** Approximate Interval Between Onset and Death 4517 PARK HEIGHTS AVENUE 23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician ar s the burial-t P.O. Box 68760, Physician/Medical ası been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this if Director: After this id in by the tuneral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Momicide 11. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certified

To the Hospital or Attending Physician: within 24 hours after To the Funeral Direct pellit /

> State Registrar

DHMH 17 Rev 1/2001

2004

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

Maria

110 604

32. Registrar's Signature

Borodatcheva

beed other M.D.

who completed cause of death (Item 23a) (Type, Print)

Clo Marxland

21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

GENERA

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** July 12, 2004 George Gayo 11:40 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore 419 Margaret Avenue Essex 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months Days 1**☑** M 2□ F Hours July 17,1912 Director 217-03-9299 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County 23a or 28a-f show 1 Yes 2 No Maryland Baltimore Essex Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 419 Margaret Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 N Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Bricklaver Construction 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other 1 any Injury or other treumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Christopher Gayo Christina Hines ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Toft (Granddaughter) 808 Essex Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩Burial 2 ☐ Cremation 3 ☐ Removal from State July14,2004 Baltimore, Maryland `4 Donation 5 Other (Specify) Gardens Of Faith 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Liceges Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final Physician ovency disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2: autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No Physicien: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

Injury at 28d. escribe how injury occurred 1 Tes 2 No 2 ER/Outpatient 3□ DOA Medicai Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Natural 2 Accident 5 Pending investigation 2 No death. the hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours To the Funerel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. the the License number 29b. Signature and little of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milner, MD 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (*Month*, *Day*, *Year*) **JUL 1 6** 2004

Pamela E. Southall, MIS



111 Penn Street, Baltimore, Maryland 21201

				State of Maryla	and / Den	artment of Healt	th and Mental H	vaiene		
			For State Registrar	Otate of Waryte		rtificate of Dea		Reg. No.	nni	22305
			Decedent's Name (First, Middle, Last)			2. Date of	Death	() () (o)	3. Time of Death
	Physici /Medic		ROBERT			Hen	RY JUL	Day	200 4	11:45 AM
	Examin		4a. Facility Name (If not institution, give	street and number)	1	4b. City, Town, or Loca	tion of Death	4c.	County of Death	
				kins Hospit	M	Bultmore				
	Funeral Director		5. Social Security Number 6.% 6.1 6.1 6.1 6.1 6.1 6.1 6.1 6.1 6.1 6.1	X M 2□F 7. Age (In yi	rs. last birthday, Yrs.	Months Days Ho	urs Min. 1. Date of (Month, May 6	Day, Year)	Cour	
			Usuel Residence of Decedent				riay 0	1724	raly	land
	how		10a. State 10b. County	10c.	City, Town or L				1	0d. Inside City Limits
	8a-fs	cto	MD		Baltim					1X Yes 2 No
	with the	<u>e</u>	10e. Street and Number 1 W. Conway Stre	o+ #615		10f. Zip Code 21201			zen of What Cour	ntry?
	filed within 72 hours after death with the Maryland Hygiene thar than "natural", or items 23a or 28a-f show thar than medical Examinat remaths incitified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		c Origin? (Specify Yes or		JSA 14. Race - Americ	ean Indian,
(0	or iten		1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ⊠ Yes 2 ☐ No If Yes, Give			c Origin? (Specify Yes or xican, Puerto Rican, etc.)		Black, White,	
ğ	ral', c	dby	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 143	- 45	1 ☐ Yes 2 █ No Spe	ecify:			iite
2	natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Occupation a kind of work done during DO NOT use retired)	most of working	16b. Ki	nd of Business/In	dustry unk
2	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1110.	sales				
<u>0</u>	filed Hygi othar ent, I	Be C	17. Father's Name (First, Middle, Last)				Mother's Name (First, Mide	tle, Maiden	Sumame)	
lan	Jenta Jenta rked tic ev	To B	John Oliver He	≥nry			Anna Evelyn	Hanra	tty	
Maryland 21215-0036	and h		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ing Address (Street and N	umber or Aural Route Nur	nber, City o	Town, State, Zip	Code)
≥	and lealth m 27 her tr		Margaret D. Henr			. Conway Str	eet #615 Bal			.1201
jor	iges 1 it of the if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from Stafe	cemetery, cre	matory or other place)	Date	200. LO	cation - City or To	own, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Lancellina at ODGe.		* 4 ☑ Donation 5 ☐ Other (Specify,	4	2	2. Name and Address of F	Facility			
Ba	Depa impo any i		21. Sunature of Euneral Straige Licens ROD Q S	wade, Direct	ør S	tate Anatomy altimore, MD	Facility Board 655 V 21201	I. Bal	timore S	Street
			23a. Part1. Enter the disease/or comp shock, or heart failure. List only of	lications that caused the de				arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	HYPOXIC	Resp	IRATORY F	HILURE			Onset and Death
	/Medical		resulting in death)	Due to (or as a cons	sequence of):	^ .				20473
8	Examiner	Ļ	Sequentially list conditions,	b. Metast		Hdenocarc	MOMA			month
	per list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
	al-tran	xan	that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
760,	ficate be executed physician and is the burial-transit	cail		d						
68	ntificat ng phy as th									
	es ign	~	IS SSMALE.							
30X	the ster	an/Me	230. Was decedent pregnam	23c. If yes, outcome of pred 1☐Live birth 2☐F		□Ectopic pregnancy		2	3d. Date of delive	
O. Box	ne death the atter hed for u	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		etal death 3	□Ectopic pregnancy □ Other (specify)		- 2	3d. Date of delive Month	ery Day Year
P.O. Box	that the death ed by the atter detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 of death 5	Other (specify)	Part I. 23e. Di		Month	
P.O. Box	uires that the death certifica signed by the attending ph lid be detached for use as th		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions co	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 of death 5	Other (specify)			Month se contribute to the	Day Year
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			State of Maryland / Department of Health a 1 - State State State AMEND ITEM #20b PER FH C834 8/10/10/16/10/16	ind Mer		ne No2 A A L	0.0
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 12 04	10:20AM
	Examin Funeral Director		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Part 1 5. Social Security Number 6. Sex 7. Age (In)rs. last birthday) 1 Usual Residence of Decedent 4b. City, Town, or Location of Part 1 4c. City, Town, or Location of Part 1 4d. City, Town, o	nore	Date of Birth (Month, Day, Y	ear) 9. Bir	th A thplace (State or Foreign buntry)
	Maryland a-f show	ctor	10a. State 10b. County NA Baltimore			-	10d. Inside City Limits 1. Yes 2 □ No
	s 23a or 28	Funeral Director	10e. Street and Number 10f. Zip Code 21201 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig	nin? (Spacify		. Citizen of What C	A
036	ours after de ral', or Item Examiner d	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 □ Yes 2 ☑ No Specify:	, Puerto Rica	an, etc.)	Black, Whi	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Macified Establisher nust be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	16	b. Kind of Business	/Industry
Maryland 2	12 should be filed with n and Mental Hygiene. Is marked other than raumatic event, the N	To Be C	unk	·	irst, Middle, Ma		unk
altimore, Mar	5 = 2 :		19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 8/12/	St. B	c. Location - City or	d. 21229
Baltin	permit. Pages 1 ar Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service (Icensee) 22. Name and Address of Bushing 23. Name and Address of Bushing 24. Name and Address of Bushing 25. Name and Address of Bushing 26. Name and Address of Bushing 27. Name and Address of Bushing 28. Name and Address of Bushing 29. Name and Address of Bushing 20. Name and Address of Bushing 20. Name and Address of Bushing 20. Name and Address of Bushing 20. Name and Address of Bushing 21. Name and Address of Bushing 22. Name and Address of Bushing 23. Name and Address of Bushing 24. Name and Address of Bushing 25. Name and Address of Bushing 26. Name and Address of Bushing 27. Name and Address of Bushing 28. Name and Address of Bushing 29. Name and Address of Bushing 20. Name and Address	iss 1	Tuner	al Home	71216
	Physician		23a. Pan Enter the disease, or complication that cause the eath. Do not enter the mode of dying, such as a shoot, or heart failure. List only one cause on each line. Immediat Cause (Final disease or condition				Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Sequentially list conditions, b.				
8760,	sate be executed ohysician and the burial-transit	ai Examine	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
P.O. Box 687	death certific e attending p nd for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify)			23d. Date of de Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				o the cause of death? robably 4 🖼 Unknown
Vital Records,	The ate h page	Completed			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
	Physiclan: Th r this certificate ral director, pag	To Be	evaminer?		Check only one) 5 🔲 Residen	ce 6 □Other (Spe	ecify)
Division of	ending Pl sath. or: After the		27. Manner of Death 1 Manual 5 Pending investigation 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Accident investigation M 1 Yes 2 N	No		injury occurred	
Divis	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town,		
	the Hosp in 24 hou the Funel	fedical	29a. Certifler (Check only one) 2D Medicel Exeminer: On the best of my knowledge, death occurred at the time, date and check only one) 2D Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, deat and manner stated.		at the time, date		e to the cause(s)
)	with To	M	April 200 MD 821 NEULaw ST D3912	*		7/13/04	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HHMED MD & ZI N. Euttin & T. Ballimore 31. Date filed (Month, Day, Year) Registrar's Signature	MI	> 21	201	
	St Regist	ate rar	JUL 1 6 2004 August Signature				

	vin Joh	ns		Please Amend	Type or Pri	t in Black Inf.	ndelible l G836, I	BK7/04 TT	All Copies	Are Legible.	
04 RJ	-04371		State	nd Item #	4b ^{State} of M	arviand / Der	1232,27	of Bealth and of Death7/2	me G833	iene	00007
T.O		30	Registrer 1. Decedent's Nar	ne (First, Middle, La	st)		rancato	or Boarry Z	2. Date of Deat	h	3. Time of Death
	Physicia		te2	in NI	1	hnson			July 4	Day Year 2004	0457_A.M
3	/Medic Examin		4a. Facility Name	(If not institution, giv	e street and number)		4b. City, To	wn, or Location of Deat	h	4c. County of Dea	
5	4.	ę.		Regional I		11 1 1 1 1 1 1		aurel Year If Under 24 Hrs	O Date of Bigh	Prince C	
77	Funeral		5. Social Security	4	EM 2 F	e (In yrs. last birthda Yrs.		Days Hours Min.		Year 50 M	rthplace (State or Foreign JPP 4Laine
7	Director		Usual Residence	of Decedent		75			700	- C) IVI	regund
	show	_	10a. State	10b. County		10c. City, Town or	1				10d. Inside City Limits
	ith the Ma or 28a-f s or notifie	Director	MARyland	4		130	101. Zip Ci			0g. Citizen of What C	
	is after death with the Maryla , or Items 23c or 28a-1 show caminar must be notified at		10e. Street and N		Hon Ar	10	101. 2IP C	1.7 :	'	1) 5	A
	ter death w Items 23c	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S. 1	3. Was Deceder	nt of Hispanic Origin? (S	Specify Yes or No-	14. Race - Am	
ي	or Ite		1 🗌 Never Ma	rried 2 Married	Armed Forces? 1 Yes 2 If Yes, Give		1 Yes 2	Cuban, Mexican, Puer	to ricall, etc.)	Black, Wh	N Lac 1
003	ural',	d by	3 Widowed	4 Divorced	Year or Dates:	10.0					3Laci -
15-(n 72 h	lete		15. Decedent's E ecify only highest gra	ade completed)	(Gi	cedent's Usual (ve kind of work of , DO NOT use	done during most of wa	orking	16b. Kind of Busines	sylindustry ,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23c or 28s-1 show ont, the Micrical Examiner must be notified at	Completed	Elementary/Se	2 (0-12)	College (1-4or	5+) N	rking	with t	Lastic	Frable	aleon
	0 = 0 %	Be C	17. Father's Nam	e (First, Middle, Last			1	18. Mother's Na	me (First, Middle, I	Maiden Surname)	Van James
<u>ya</u>		To	John		nsow			Max	10 S	0 h " 5 0 1	July 130M2
Maryland	d2s har 7 Is trau			Name/Relationship (Type, Print) Vic	lker 196. Ma	aling Address (S	Street and Number or R	urai Houte Number	City or rown, State,	to Md.
	1 an Heal em 2 ther		20a. Method of D	isposition		20b. Place of Dis	position (Name remajory or other	of or proper	Date	20c. Location - City of	r Town, State
ē	Pages nent of l int: If It			2 Cremation 3 C	Removal from State (fy)	1/oshe	1/Com	elery 7/	10/04	Barto	·mx
altimore,	permit. Pages Department of I Important: If Ite any injury or or once.			Funeral Service Lice			22. Name and	Address of Facility	Wiler	pmetto.	Chapel
<u> </u>	89 5 5 8		110	Haylet	alle		1639	$N \cdot B$	ronda	say	
			shock, or h	eart failure. List only	one cause on each I	d the death. Do not o ine.	enter the mode	of dying, such as cardia	ic or respiratory arr	est,	Approximate Interval Between Onset and Death
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	Examiner	Н	3	- 1	Due to (or as	a consequence of):					
	6,33	Jer	Sequentially list if any, leading to Cause (Disease	conditions, immediate	b. Due to (or as	a consequence of):					
	cuted nd ransit	Examiner	triat initiated ever	11.5	c						
60,	sician and burial-transit	1	resulting in death) Last	Due to (or as	a consequence of):					
687	death certificate k attending physic I for use as the b	Physiclan/Medical			d						
×	certifi nding Ise as	√Me	IF FEMALE: 23b. Was deced	ent pregnant	23c. If yes, outcome		-			23d. Date of d	elivery
Box	death e atter d for u	iclar	in the past	12 months?	4 Pregnant a		3 □Ectopic preg 5 □ Other <i>(spec</i>			Month	Day Year
P.O.	at the de by the stached	hys	9 Unknow	wn	9□ Unknown						4 4 - 16 2
	w requires that the death cer been signed by the attendir should be detached for use	by	Part II. Other sig	nificant conditions	contributing to death	but not resulting in the	underlying cau	ise given in Part I.			to the cause of death? Probably 4 Unknown
ord	v requir been si should	eted									
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of Vital Records,	rician: The lav certificate has rector, page 2		25 Was case re	ferred to medical				26 Place of De	1 PYes eath (Check only or	2 No 100	es 2 No
E	ysicia is cert direct	To Be	examiner? 1 X Yes 2		Hospital: 1 Inpat	ient 200 ER/Outpa	tient 3 DOA	Other		ence 6 Other (Sp	ecify)
0	ding Phys		27. Manner of De	eath 5 Pending	28a. Date of Inj	ay Year) FOUN	of 280	c. Injury at Work?	28d. Describe h	ow injury occurred	
Sio	death.	catle	2 Acciden	income Almonton	ⁿ 7/4/04	3:18	a [™]	1 ☐ Yes 2 🛣 No	Unkno		Burel Bauta Alumbas
Division	or At after d Direct in by	Certification;	4 Homicid	determine	Found	njury - At home, farm, bic. <i>(Specify)</i> In cell	street, factory,	Office	Correct	ion, Jessu	nd House of
	spital		29a. Certifier	1 ☐ Certifying P	hvsicien: To the bes	t of my knowledge, de	eath occurred at	the time, date and place	e, and due to the c	ause(s) and manner	as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only one)	2 Medical Exe	miner: On the basis and manner s	of examination and/o	r investigation, i	n my opinion, death occ	curred at the time, d	late and place, and di	ue to the cause(s)
	To the To the Comp	ž	29b. Signature a	nd title of certifier) (A	4 - 1 ^	29c.	License number	2	9d. Date signed (Mo.	
	•		M	ayrite !	bre you	u m)		OCME		July 5,	200 4
			30. Name and a	ddresslof person who	completed cause of	death (Item 23a) (Ty	111 P	enn Street,	, Baltimo	re, Maryla	and 21201
	St	ate	31. Date filed (M	Ionth, Day, Year)		trar's Signature	<u>.</u>		:		
	∵ ⊸ Regist			JUL 162	004	48 H. A	fraction				

	JE L		1 - For State Registrar AMEND TTEM 1. Decedent's Name (First, Middle, Last)	#9 PER FH	833 7/1	STOTICATE O	i Death	2. Date of Deat		3. Time of Death	
	Physicia /Medic		Maxie Joseph	Jones				July ,	Day Year	, 2130 M	
	Examin		4a. Facility Name (If not institution, give			and the	, or Location of Death		4c. County of De	ath	
			SAINT AGNES!				or If Under 24 Hrs.	Done of Birth	N/A		-
	Funeral Director		5. Social Security Number 6. September 214-18-5837		(In yrs. last birtho	Months Day		8. Date of Birth (Month, Dey, Apr. 2	Year) 1915	irthplace (State or Foreign Country) YIRGINIA	
land	MOI THE		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits	-
Man	a-f sh lifted	ctor	Maryland N/A		Balt	imore				XXYes 2 □ No	
ili th	23e or 28e-f show ust be notified at	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?	
aath w	s 23a	ra	3106 Elbert Str			212			USA		
d 21215-0036 Iled within 72 hours effer death with the Maryland	- E	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes \$ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ver in U.S.	If Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto Bo Specify:	Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.	
Baltimore, Maryland 21215-0036	and Menial Hyglene. ie marked other than "natural", sumatic event, the Medical Exe	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(C	ecedent's Usual Occ ive kind of work don ie. DO NOT use reti	supation ne during most of work red)	king	16b. Kind of Busines	s/Industry	
212 d with	Hygiene. ther than	mo	9th grade	College (1-4or 5+))	Steelwo			Armco	Steel	
ם 🚆	al Hyg l othe vent,	3e C	9th grade 17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M		DUCCI	-
arylan should be	Mental arked o	To Be	Paul Jones				Minnie	B. Lee			_
Mar 12 sh	th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (Ty Idella Jones/ W	,	19b. M	ailing Address (Stre	et and Number or Rur	al Route Number,	City or Town, State,	Zip Code) 21229	
e -	Hear em 2 ther		20a. Method of Disposition	110	20b. Place of D	sposition (Name of crematory or other p.	t Street		lore, Mai 20c. Location - City o		
MOF	ant of at: If it y or o		1 → Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Cometery,	crematory or other p Park Co	emetery ^{7/}				
Baltir Permit. P	Department of Important: If is any injury or once.		21. Signature of Fineral Service Ligense	90		22. Name and Add	ress of FacilityCh	<u> </u>	altimore	, Marylan	
m §	2 4 4		Grey Lair	,		5240 Rei	sterstow	тman-на n Rd Ba	arris Fu Altimore	neral Home ,Md 21215	
			23a. Part 1. Enter the disease, or complished, or heart failure. List only or	cations that caused the cause on each line	he death. Do not	enter the mode of d	ying, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
	ysician		Immediate Cause (Final disease or condition resulting in death)	Upper	GASTE	ROINTE	STINAL	BLE.	5D.	Onset and Death 3 WEEKS	
50%	Aedical aminer				dorsequence of):	Li Com (SALCIND	011.			
1/1	E.	er	Sequentially list conditions, if any, leading to immediate		consequence of):	TUENO	MACIOS	TUIT			
m B	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
760, \$\\ 18 \text{De executed}	ician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
9	s e	dical		1.							-
	attending p	Physician/Med	IF FEMALE:	3c. If yes, outcome of	nregnancy						7
Box death cert	atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti/	☐ Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)			23d. Date of de Month	Day Year	
o. at	ed by the a	hys	9 Unknown	9□ Unknown							
S, P		ру Р	Part II. Other significant conditions con	tributing to death but	not resulting in th	e underlying cause g	given in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
ord equire	been si	ted						1 🗌 Ye	s 2 No 3 F	robably 4 QUnknown	
Records,	as be	Completed						24a. Was ar autopsy	v prior to	autopsy findings available completion of cause of	
	cate hg	S						perform	red? death?	s 2NNo	
of Vital	90 90	Be	25. Was case referred to medical examiner?	lospital:			26. Place of Deat				1
子の事	shis di	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Tim	Hent 3L DOA		me 5 Reside	nce 6 □Other (Spewiniurv occurred	ecify)	
Vision	: After s funer	flon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	Year) Inju	y W	ork? □Yes 2 □No	204. 00001100 110	w injury cocarrod		
Division lor Attending	aner deam. Director: A In by the fu	Eg	3 Suicide 6 Could not be determined	28e. Place of Injury	y - At home, farm.	street, factory, office	8	28f. Location (Str	eet and Number or F	Rural Route Number,	
Div Hospital or	al Dir	Certification;	- I Tomode	building, etc.	(Op o uny)			City or Town	, Jiale)		
I I Hospital		edical (29a. Certifier 1	sician: To the best of ner: On the basis of e and manner state	xamination and/o	eath occurred at the r investigation, in my	time, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)	
To the	To th	Me	29b. Signature and title of certifier	11/			nse number		d. Date signed (Mon	th, Day, Year)	-
	1		Matomalal	MED)ICALD	OCTOR A	524385	28 3	Tuly 7,	2004	
	5		30. Name and address of person who co RABINA MALIK	mpleted cause of dea		ne Print)				TLAND 21229	
											4
76,	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	/					Ì

			For State Registrar	State of	f Marylan		artmen rtificat				nental Hy	giene Reg. No	200	l.	22300
	Dhara's	盐	1. Decedent's Name (First, Middle	a, Last)							2. Date of De	ath		4	3. Time of Death
	Physici /Medi		Rosalie	Vi	ctoria	May	Jo	hnso	n		July 12	2 , 2	004 [°]	ear ear	4:00 P M
	Examir		4a. Fecility Name (If not institution	, give street and num	nber)		4b. City,	Town, or	Location of	of Death		40	. County of	Death	
			Bradford Oaks	Nursing H	lome		Clin	ton				P	rince	Geo	rge's
	. Funeral		5. Social Security Number 577-42-4937	6. Sex 1 ☐ M 2 X CXF	7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir	th v. Year) g	9. Birthpl	lace (State or Foreign try) England
	Director			10111 2221	94	Yrs.					08/11	/190	9		""England
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				-			11	Od. Inside City Limits
	ith the Marylar or 28a-f show e natified at	0	Maryland Prince	George		nton									1 ☐ Yes 2 🕅 No
	the 28a-	ec.	10e. Street and Number				10f. Zip	Code	-			10a Ci	tizen of Wha	al Caus	
	23£ or	by Funeral Director	7520 Surratts R	oad			TOIL CIP		735			iog. Ci	USA		пуг
	ns 2	era	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13. \	Vas Deced			ain? (Sp	acify Yes or No	h=	14. Race -		an Indian
(0	r itar	E	1 Never Married 2 Marr		2 (20No		f Yes, spec	ify Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)			White, e	etc.
03	al', o		3€XWidowed 4 □ Divorced	If Yes, Give Year or Da	e ites:		I□Yes ː	XX No	Specify:				Specify:	Whi	te
2-0	within 72 hours after death with the Maryland ene. than "natural", or itams 23c or 28e-1 show is Modical Exercities must be multied at	Completed	15. Deceden	('s Education		16a. Deced	lent's Usua	I Occupa	ation	t of words	ina	16b. K	(ind of Busin	ness/Ind	ustry
2	ithin le.	nple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self-employed Ke							Von	1 0				
21	ygier ygier yer th		10			pert-	empro	yeu					nel 0	wiiei	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla t of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23c or 28a-f show or other traumatic event, if a Modical Exertifier marke encitined as	Be	17. Father's Name (First, Middle, Walter Collins								's Name <i>(First, Middl</i> e, <i>Maiden Sumame)</i> Rose Annie Bruck				
3	Mer Marka	L _O													
Val	12 st		19a. Informant's Name/Relations	nip (Type, Print)							al Route Numbe				
	Health Health tem 27 othar tra		Edith Pulscak		20h B				k Koa						and 20744
õ			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)									ocation - Cit			
Baltimore,	t. Page rtment rtant: It		`4 □ Donation 5 □ Other (S		Kas	las Cre		-		7/14/		_		-	aryland
Bal	permit. Pages 1 a Department of Hes Important: If item any injury or otha once.		21. Signature Funeral Service	Licensee		22	. Name and	d Addres	s of Gacilit	rge	P. Kala	ıs Fu	unera]	l Ho	me PA
			230 Phat Salar the displace of	en j			100 (Jxon	Hill	Koa	d Oxon	Hil.	l, Mar	ryla	nd 20745
		Ů.	23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on ea	ich line.		- 6-			200					Approximate Interval Between Onset and Death
	Fnysician /Medical	0	Immediate Cause (Final disease or condition resulting in death)	_ a	terus	dust	00	200)	000	ala	· DIS	54	E		GEAN
信	Examiner		,	Due to (c	or as a consequ	uence of):									
ļ.		<u>-</u>	Sequentially list conditions,	b. Due to (c	or as a consequ	ience of):		_						_	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	\$ 550.50	40 4 001.004	201100 01).									
_,	be executed sician and burial-transit	хаг	that initiated events resulting in death) Last	c	or as a consequ	uence of):								-	
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical													
89	fficate I g physi	edlo		d											
ŏ	leath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc								1	23d. Date of	f deliver	v
m	death e atte d for	icla	in the past 12 months?	4□Pregna	th 2∏Fetal int at time of de		Ectopic pre Other (spe						Month		Day Year
0	at the de by the tached	hys	9 □ Unknown	9□ Unknov	₩n										
Is, P	The law requires that the te has been signed by th vage 2 should be detache	by P	Part II. Other significant condition	ns contributing to dea	ath but not resu	ulting in the un	derlying ca	luse give	n in Part 1.		23e. Did to	bacco u	ise contribu	te to the	cause of death?
rds	quire an sig	ed t									1 🗆 Y	es 2	20No 3E] Proba	bly 4 □Unknown
Record	law requas been 2 should	ompleted									24a. Was		24b. Wer	e autop	sy findings available
Ä	The I	E O										rmed?	prior	r to com th?	pletion of cause of
Vital	ian: Th rificate tor, pag	Se C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o	No Rel	1 🗆	Y 0 S 2	! No
\	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🙀 🎖o	Hospital: 1 ☐ In	patient 2 1	ER/Outpatient	3 DO	A Other	. 1		ne 5 Resid		8 ∏Other /	Specify)	
J of			27. Manner of Death	28a. Date of	Injury , Day Year)	28b. Time of Injury	28	Bc. Injury Work			28d. Describe h			ороопу	
<u>0</u>	at at	atle	1 ★ Pending 2 Accident investig	ation	,,,	,u.y	M		es 2□N	No					
Division	r Att	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determine	ned 286. Place of	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory,	office		2	28f. Location (S City or Tow	treet and	d Number o	r Rural	Route Number,
	ital or irs afte ral Dir	Se										., 5.4.0,			
	To the Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	edical	(Check billy 2 Medical I	g Physician: To the bearing: On the bas	est of my know	vledge, death	occurred a	t the time	e, date and	d place, a	and due to the o	ause(s)	and manne	r as stat	ted.
	the hin 2 tha i tha i	Med		and manne	er stated.										
	with to con	2	29b. Signature and title of centrier	r			290.	License	number		2	29d. Date	e signed (M	fonth, Da	ay, Year)
•	\wedge) 17	42/			11	13/64		
	1		30. Name and address of person v	who completed cause	of death (Item	23a) (Type, F	Print)	14	6/10	For	-/10.1	-1- he	111.	1	20111
	J		31. Date filed (Month, Day, Year)	7000	11016	Jung!	12/	0 "	100	11	· wyjn	Ng 10	v (W	17	199
d _e	Sta Registr			2	gistrar's Signat	L	/	,							
0.5			JUL 1 6 200	4 Allege		~ D	week	2/							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Yeer **Physician** Bertha Johnson 13 10:15 AM 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis OF Randallstown Randallstown Baltimore, Co. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 XF 89 Yrs Vírgania 214-22-3257 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or Items 23a or 28e-f show ury or other traumatic event, Item Madigul Examinating the Inditional. 1X Yes 2 No Director Md. N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 Harford Ave. 21202USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Yes 21 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Custodian Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Helen Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6728 Campfield Road, Baltimore, Md. Kathy DeVilles Neice 2120220b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or Garrison Forest 7-21-04 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md. 21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility
Estep Brothers Funeral 3

1300 Eutaw Place, Baltime

23a. Pent. Enter the disease, or complications that caused the death. Shock, or heart ailure. List only one cause on each line. Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a larger to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months Month Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown been signed the should be detected Part II. Other significant conditions contributing to dealir but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Hinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has 1 Yes Division of Vital 2 Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 2 **□ÛN** 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 SNatural Injury 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: 2 Accident investigation by the f 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 😢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 21208 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 6 2004 Registrar

cpm 04-04453 Craig Joyner UNK 04-236

with the Maryland

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760,

P.O. I

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month July Physician 07, Craig B. Joyner 2004 14:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1600 block of North Gay Street Date of Birth (Month, Day, Year) Aug 25, 1979 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** Min Months Days Hours **№** М 2 🗆 F Maryland 24 Director 218-96-8326 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28e-f show other treumatic event, the Medical Examiner must be notified at X 1 ☐ Yes 2 ☐ No **Baltimore** Director Maryland N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21213 3421 Kentucky Ave. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Menial Hygiene. Importent: if Item 27 is marked other than "naturel, or items 23a any highry or other treumatic event, the Medical Examples 2008. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2X☐ No Black 1 ☐ Yes 2 No Yes. Give Specify: Specify δ lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Private Co. Elementary/Secondary (0-12) College (1-4or 5+) Mover 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sandra Peav Craig Joyner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3421 Kentucky Ave. Baltimore, Maryland 21213 Sandra Peay Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/14/04 Baltimore, Maryland Holly Hill Memorial Gardens A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Home P.A. 21. Signature of Funeral Service Licensee 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MULTIPLE GUNSHOT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): physician Physician/Medical the use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 🗀 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 🗆 No 2 No 1 Yes Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica Be 25. Was case referred to medical examiner?
1X Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation SUBJECT WAS SHOT 7/7/04 2:50 P 1 Yes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) determined 4 Homicide 1600 BLK N. GAY ST, BALTIMORE, MD 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. July 08, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

ANA

HI 1 6 2004

31. Date filed (Month, Day, Year)

HD

32. Registrar's Signature,

RUB10,

			1 - For Stata Registrar	State of Maryla			of Health a of Death	ind Mental Hy	giene	no.	22312
			1. Decedent's Name (First, Middle,	Last)				2. Date of De			3. Time of Death
	Physici √Medi		JAMES	5 OWARD	10%	22		Month JUL	Day	Year 4. 2004	2:00F M
	Examir		4a. Facility Name (If not institution,	-		4b. City, Tov	wn, or Location of	f Death	1	County of Death	
			Saint Joseph	Medical Cen	iter		Tot	wson		Balt	imore
	Funeral		5. Social Security Number 6		s. last birthday)	If Under 1 Y Months D	ear If Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da	th V Year	9. Birth	plece (State or Foreign
	Director		073 18 5419	18 M 2□F 30	Yrs.	Wiorigins	ays Hours	MARCH	1319	371 150	YORK
	pu ,		Usuel Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	andin -)		
	the Marylan 28e-f show notified at	-	Toa. State Tob. County	100.0	ony, rown or Lo	Cation					10d. Inside City Limits 1 ☐ Yes ② No
	86-f	octo	LIMATHO BUTT.	imore	1,00	CIVM					
	or 2	Dire	10e. Street and Number	1		10f. Zip Co	ode		10g. Citi	zen of What Cou	ntry?
	ath v	ā	3 FOOTHIN	LOURI		181	1003			D-5-61	`
	er de Items	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent If Yes, specify	t of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	-	 Race - Ameri Black, White, 	
36	s aff	by F	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	d fXYes 2 □ No If Yes, Give Year or Dates: \\		1 □ Yes 2 / □	No Specify:			Specify:	1
5-0036	72 hours after death with the Maryland naturel', or items 23e or 28e-1 show licel Exentrative to notified at	pe	15. Decedent's		162 Doop	dent's Usual O	locupation		tob Ki	W	31112
215	in 72	Completed	(Specify only highest	grade completed)	(Give	kind of work d DO NOT use re	lone during most etired)	of working	160. KII	nd of Business/Ir	dustry
212	filed within Hygiene. Ither then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	GA	K Le	LANAL	5 -Q	1	2006	READ
	filled Hyg other		17. Father's Name (First, Middle, La	ast)	1 400 6 1	.,,,	18. Mother	's Name (First, Middle,	Maiden		(OFI: I
Maryland	Mental Mental arked o	To Be	THOMAS	27401			KA	THERINE	1	0011	60
2	should and Men is marke	-	19a. Informant's Name/Relationship	o (Type, Print)	19b. Mailir	ng Address (St	treet and Number	or Rural Route Number	er. City or	Town, State, Ziu	Code)
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ē,	- 7 6 5		20a. Method of Disposition	20b.	Place of Dispo	sition (Name o	of .	Date	20c. Lo	sation - City or To	
JU O	00 ===		1 Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		cemetery, crei	natory or other	piace)	14.17 next	i	· ^ ·	Challan
Baltimore,			21. Signature of Full all Sarvice L	140	22	. Name and A	ddress of Facility	12 1 1 200 1	1110	2012	CHAINE
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ı			shock, or heart failure. List de Immediate Cause (Final	ly one cause on each line.			-, -, 51				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a ASPIRATIO		MONIA				7	DAYS
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	1 7	ē	Sequentially liet conditions, if any, leading to immediate	Due to (or as a conse		14107(2)14	o wader	101		-	
	t insit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	W/2 18 18 19 19 19 19	TITLE IN	e. 11290	era ministra	4			ويوس يشكل فالمال ا
-	al-tra	xa	that initiated events resulting in death) Last	c. Due to (or as a conse		D. Birth	ner and	LINE PLATE		X	EARS
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Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					2	3d. Date of delive	erv
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of]Ectopic pregna] Other (s <i>pecif</i>)				Month	Day Year
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<u>ر</u>	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by P	Part II. Other significant condition	s contributing to death but not re	esulting in the u	nderlying cause	e given in Part I.	23e. Did to	bacco us	se contribute to th	ne cause of death?
ř	quire on sig uld b							1 D Y	'es 2 🗓	No 3□ Prob	ably 4 Unknown
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ta		0	25. Was case referred to medical				26 Place	1 ☐ Yes of Death Check onload	2 No	1 ☐ Yes	2 No
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of		L L	27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at Work?	28d. Describe h			′′
ion	Attending I r death. sctor: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury		work? 1 ☐ Yes 2 ☐ No	0			
Division	of or Attency after death Director:	ific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 286. Place of injury - At		eet, factory, off	fice			Number or Rura	l Route Number,
Ö	s afte	Certification;	4 El Hollinoide	building, etc. (Spec	эту)			City or Tow	n, State)		
	To the Hospitet or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Cartifying (Check only 2 Madical Ex	Physician: To the best of my kr	nowledge, death	occurred at th	ne time, date and	place, and due to the o	ause(s) a	and manner as st	ated.
	n 24 he Fu	edical	one)	aminer: On the basis of examinand manner stated.	nation and/or inv	estigation, in n	my opinion, death	occurred at the time, o	date and (place, and due to	the cause(s)
	To the within 2.	Σ	29b. Signature and title of certifier	00 - ()	29c. Lic	cense number		29d. Date	signed (Month,	Day, Year)
			▶ Ul	allo, Mi	/	Di	25886		Sul	4-15	-2004
	UX'		30. Name and address of person wh	no completed cause of death its	em 23a) (Type,					1	
_	10		LILIA CEBALLO	3 M.D. 7601	DSLER	DRIVE	TOWSON	LMARYLANI) 21	204	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	nature	parke					
	Registr	ar	UU 1 6 200	4 Serva	ps p	yours					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da Physician Mary Kilickowski July 15, 2004 8:00 p^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1607 Gunpowder Ridge Road Joppa Harford If Under 1 Year Months Davs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) NOV. 1, 1915 Birthplece (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🕅 F 88 Director 132 12 1904 Massachusetts Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itema 23s or 28s-1 show any injury or other traumatic event, the Wudical Examinar must be notified as once. Maryland Harford Director Joppa 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1607 Gunpowder Ridge Rd. 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 8 Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Unk. Virginia Kyrus White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Feser (Grandson) 1607 Gunpowder Ridge Rd. Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith 7/19/2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and ddress of Facility Bruzdzinski Funeral Home, P.A. okn W. Old Eastern Avenue, Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (mc) lease /Medical Due to (or as a conseque Examiner Hero &clenotre Pagers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. | 1 ☐ Yes 21X No 9 Unknown 9 Unknown ģ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy this certificate 1 Yes 25 No ours after death.

Neral Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 🖽 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D0056607 n) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAFR # 205 # ATWOOD RD JOSEPH ANGELO 60 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6

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7	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) FREPENICK 4a. Fecility Name (If not institution, give st	KESSLE R Treet and number) LE MED. CENTER	4b. City, Town, or Location of Death	2. Date of Death Month JULY 10	Day Year	3. Time of Death 925 A M
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Maryland 21215-0036	be filed within 72 hours aft tal Hygiene. d other than "natural", or event, the Medical Exami	Completed b	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) unk	College (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing unk 16b.	Kind of Business/Indus	stry unk
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rds, P.	w requires that is been signed by should be detailed		Part II. Other significant conditions cont	ributing to death but not resulting in the u	ndertying cause given in Part I.	23e. Did tobacco	o use contribute to the o	1.0
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Divis	tal or Attendi rs after death. ei Director: A ed in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural R ite)	oute Number,
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	Funeral		5. Social Security Number	v Number 6. Sex 7. Age (In yrs. last birthday)						24 Hrs.	8. Date of Birt (Month, Da	h Year	9. Bi	thplace (State	or Foreign
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	pu *		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							10d. Inside C	City Limits				
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	the ?	Director	10e. Street and Number 828 N. Eutaw Street				10f. Zip C	Code				10g. Citize	. Citizen of What Country?		
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<u>E</u>	Page ment c ant: If ury or		1 Burial 2 Cremation 3 Removal from State '4 X Donation 5 Other (Specify)												
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exactle remarker rediffied at once.		21. Six altura di Funeral Service ROHATO	11 11 11 11	STREET	St	Name and Late And	nato	my B	oard	655 W.	Balt	imore	Street	
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			30. Name and address of person	who completed caus	se of death (Item	23a) (Type,	Print)	FII:	14.) (7	BAL	F1 AA .	05 N	10 21	lal
	Sta	ite	31. Date filed (Month, Day, Year) 32. R	legistrar's Signa	ture ,	•				DEID	. , . 4 40	100 1	70 -11	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Year 2004 AM /Medical 4b. City, Town, or Location of Death 4c/ County of Death 4a Facility Name (If not institution, give street and number) Examiner ed f Under 24 Hrs. 8. Date more If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 MM 2□ F Months Days Hours 216-28-0393 Usual Residence of Decedent Mary Yrs. Director land permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: if New 27 ie marked other than "neturel!. or hearth and marked other than "neturel". 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2123 urne Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ZNO Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) bore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ee 2 aar 19a. Inf the t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ita, Md. 21230 larbourne Ave Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 19/2004 4 ☐ Donation 5 ☐ Other (Specify) 100 21. Signalura of Funeral Service Licenses 22. Name and Address of Feelity Joseph 2222 KUS ral Hime 21216 Baito, Md. 21216 uneray 23a. P. 11. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA HK Examiner Physician/Medical Examiner CARDIO LAYOBATH anding physician and use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2LINo 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 versing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 □ No 2 Accident

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this

s after death. To the Hospital of within 24 hours at To the Funeral D completely

State Registrar

6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARIS ALFERN 7505 01000 MM 21204 DRIVE VIDENOI

31. Date filed (Month, Day, Year)

32. Registrar's Signature

1 6 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** -Month 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mours 19 Hrs. 8 Pro-7. Age (In yrs. last birthday) iture(9. Birthplace 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** 1 M 2□ F Months Deys 7-18-0443 Director Usual Residence of Decedent death with the Meryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland 10e. Street end Number 1 XYes 2 □ No Directo more 10f. Zip Code 10g. Citizen of Whet Country? WOOd Funerai 0/1 12 Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) eamst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ 19a. Informant's Name/Relationship (Type, Print) (SISTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6, Md. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 Donation 5 Dother (Specify) ores ISOn 22. Name and Address of Facility

Seph L. Rus 21. Signature of Funeral Service Licenses Joseph S Ave. 12222 WINDETTS Balto, Md. 1216 Partil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Disease To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours either death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burnal-transit ed by the attending physician and detached for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No ģ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physiclen: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer)

State Registrar

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JUL 1 6 2004

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

39. Registrar's Signature

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	Examir		4a. Facility Name (If not institution, give street and number) 426 Lorraine Avenue					Location of De	ath	4c. County of Death Baltimore			
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in. 8. Date of Bin (Month, Da Oct. 12	th y, Year) ,1924	9. Birthpla Count Vest V	ace (State o ry) Virgir	r Foreign nia
	Aaryland f show ed at	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		Town or Lo		r				10	d. Inside C	•
	with the N 3e or 28e-	Funeral Director	10e. Street and Number 2129 Sunnythorn Rd.			10f. Zip		0		10g. Citizen of V		ry?	
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other then "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at		11. Marital Status 12. WAR	as Decedent Ever in U.S. med Forces? Yes 2 No Yes, Give ar or Dates:		Was Deced f Yes, spec		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race Blac	- America k, White, e :White	tc.	
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Gar	dens B	Of Fa . Name and ruzdz	aith d Address insk	7/1 s of Facility i Fune:	cal Home 1	Baltimon		aryla	nd
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	Ψ	10	30. Name and address of person who configlet Naeem Gauhar Essex Med 31. Date filed (Month, Day, Year)		404		ern B	lvd. Ba	altimore,	Maryland	2122	21	
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			1 For State Registrar	State of Maryla	nd / Depa			lental Hygie		22320
			1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Modia		Annie	Mae	McNe	eil		Month 7 13	Day Year 2004	8:a M
	/Medic Examir		4a. Facility Name (If not institution, give Ivy Hall N.H.	street and number)			or Location of Death		4c. County of Death	
	Funeral Director		243-26-2582	7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		lace (State or Foreign try)
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation			1	0d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show r must be notified at	Director	Md. NA		Baltimore					1X Yes 2 □ No
	or 2	100	10e. Street and Number			10f. Zip Code		. Citizen of What Coun	try?	
	ath v	Ta .	1622 N. Chapel S			21213			USA	
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212-0036	n 72 hou		15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>	16a. Dece	dent's Usual Occup kind of work done	pation during most of works d)	ng 18	b. Kind of Business/Ind	lustry
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bailimore,			20a. Method of Disposition 1			sition (Name of matory or other place) M. Park	7–15		c. Location - City or To Randallstow	
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5	Phy r this ral d	-	27. Manner Leath	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	1 3L DOA	4 Denuising nor	ne 5∐ Residenc 28d. Describe how i	e 6 Other (Specify)
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	To th To th somp	Me	29b. Signature and title of certifier			29c. Licens	e number	29d,	Date signed (Month, D	Pay, Year)
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	X		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print) 840	3+H	1 et a	CA RO	2/23/
	Sta Registr		31. Date filed (Month, Day, Year)	22. Registrar's Sign	ature	back				- / - / 7

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2004 oan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Co. Glen Burnie 7865 Crilly Rd. 485 Apt. Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Yeer) 2-3-55 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 213-62-4743 N.C. 49 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show Exercition transit be notified at XX Yes 2 No Glen Burnie Director Anne Arundel Md. 10g. Citizen of What Country? 10f. Zip Code 21060 10e. Street and Number USA Apt. 485 7865 Crilly Rd. Іветя 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or ite may hiptry or other traumatic event, the Madical Exerciting ADES. 1X Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Black f Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State of Maryland 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martin Mary Bowser Horace ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7865 Crilly Rd. Apt. 485, Glen Burnie, Md. Talaya Wiley Da hter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-17-04 Lansdowne, Md. Mt. Zion Cem. 4 □ Donation 5 □ Other (Specify) 21202 Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1101 E. North Ave March F.H. East 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner **burial-transit** or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ို 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending 2 No 1 🗌 Yes death. investigation 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide after within 24 hours a To the Funeral [Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D22/10 7-15-04 person who completed caus of de in (Item 23a) (Type, Print) "1845 Caruco Ra#300 GlenBurnie, Ma 21061 H. Kaplan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks Registrar 2004

	State of Maryland / Department of Health and Mental Hygiene 1- State State Certificate of Death Reg. NO 0.0000												
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea	th San L	3. Time of Death			
	Physici /Medio		Rebecca		Mae	Mil]	ls	Month July	13 Day	200 y	6:33 A M		
	Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)	4b. City, Town, or		Death		unty of Death			
			SiLa: Hospita	1 -f B-	1timore	Bal	1timor						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea						Year)	9. Birthp Coun	lace (State or Foreign		
	Director		220-20-5442 1 Nonth Pays Hours Min. (Month, Days Hours Min. 04 1								ĬĎ		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits		
	// sho	MD NA DOLLAR DOL									XXYes 2 □ No		
	28a	Director	MD NA 10e. Street and Number		Baltimo	10f. Zip Code			LOg Citizen	Citizen of What Country?			
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	ms 2;	era	5315 Beaufort 11. Marital Status	12. Was Dec	edent Ever in U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)		Race - Americ	an Indian,		
မွ	or ite	Funeral	1 ☐ Never Married 2 ☐ Marr	ried 1 ☐ Yes If Yes, G	orces?			Puerto Rican, etc.)		Black, White,	etc.		
g	al', c	þ	3 ☐ Widowed 4X☐ Vivorced	If Yes, Gi Year or D	Dates:	1 ☐ Yes 2 XNo	Specify:		Spe	Bla	ck		
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or items 23a or 28a-f show event. The Medical Exaction matter notified at	Completed	15. Deceden	it's Education st grade completed)	16a. Dece	dent's Usual Occupa	ation	of working	16b. Kind o	of Business/Ind	dustry		
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Maryland	e d a la la la la la la la la la la la la l	Be	17. Father's Name (First, Middle,					Name (First, Middle,	<i>Maiden S</i> un	name)			
3	a Mer narke	ပ	Melvin Corne					Hubbard					
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relations					or Rural Route Numbe					
	ges 1 and 2 should t of Health and Mer If item 27 is marks or other traumatic		Bernadette La 20a. Method of Disposition	wson-Da				Date Date		M C 2	21215		
Baltimore,	ages nt of :: If it		1 XBurial 2 Cremation		State	osition (Name of matory or other place				,			
튶	it. Partime		4 □ Donation 5 □ Other (S21. Signature of Funeral Service						Balt	imore,	Md		
Ba	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 90ce.		Fret	to K.	Thes 4		ash At	ve, Balti		, Md 2	21215		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on the	paused the death. Do not en each line.	ter the mode of dying	g, such as ca	rdiac or respiratory arr	est,		Approximate Interval Between		
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acufe Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, flany, leading to immediate Due to (or as a consequence of):										
		<u>.</u>	Sequentially list conditions, b. Coronary Artery Disease										
	lad nsit	Examiner	Sequentially list conditions, if any, leading to inhimediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
	ba executad sician and burial-transit	хаг	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
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XO	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy				23d.	Date of deliver	v		
ă	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregi	nant at time of death 5[□Ectopic pregnancy □ Other (specify)					,		
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æ	The lavate has	mo:						autops perfori	ńed?	death?	spletion of cause of		
Vital		Φ	25. Was case referred to medical				26. Place of	Death (Check only on		1 1 1 1 1 1 1	<u> </u>		
f \	d is	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 🗆	Inpatient 2 ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursii	ng Home 5 ☐ Reside	ence 6 🗆 (Other (Specify))		
n of	ng Ph Iter th		27. Manner of Death 1 Matural 5 □ Pendin	28a. Date (Mon	of Injury 28b. Time of Injury	f 28c. Injury Work	at	28d. Describe ho					
0	endir sath. or: At	atlo	2 Accident investig	gation			res 2□No						
Division	r Att ter de irect	Certification;	3 ☐ Suicide 6 ☐ Could and determined	ined 28e. Place	of Injury - At home, farm, string, etc. (Specify)	eet, factory, office		28f. Location (St City or Town		mber or Rural	Route Number,		
	ital or saf												
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On the b	e best of my knowledge, deat lasis of examination and/or in oner stated.	h occurred at the tim vestigation, in my op	e, date and p pinion, death o	place, and due to the ca occurred at the time, di	iuse(s) and ate and plac	manner as sta e, and due to	ted. the cause(s)		
	To ti withi To ti comp	Ĭ	29b. Signature and title of certifier	1		29c. License	number	2	9d. Date sig	ned (Month, D	Day, Year)		
	ta			2	M. D.	△59	062		July	13,2	004		
	m		30. Name and address of person		se of death (Item 23a) (Type,						-		
			Chad Hanse	. M. D	. 2401 W. Be	Ivedere A	ve , l	Bultimore	MO	21215			
	Sta		31. Date filed (Month, Day, Year)	32. F	. 2401 W. Be		•						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** $I \cup \mathcal{I}$ 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Farkvill-2 enter are Age (In yrs. last birthday) _ _____ Yrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year Months Days 214-69-345 **Director** Usual Residence of Decedent fited within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "neturel", or items 23e or 28e-f shov The Madical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director BALTI MORE BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21234 ISA Blvd 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 🗌 No 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Examiner MD 10 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Murar nerwood ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 permit. Pages 1 and 2:
Department of Heatth ar
Importent: If item 27 is
any injury or other treu 8800 Walher BALLINGE MO 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cametery, creptatory, or offer place) 20a. Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) - 16.-04 FOREST HILL ⁴ 4 □ Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PACTIMORE, MD 21234. EVANS FUNERAL CHAPEL, 8800 HARFORD RD 23a. Part 1. Enter the disease, or complications that caused the death To not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the burial Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 ☐ Homicide within 24 hours after To the Funerel Dire Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

Waldher

B1-3

for Enlle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Landrman

1 6 2004

31. Date filed (Month, Day, Year)

F400

32 Registrar's Signature

			. For	State of Maryla	nd / Depa	rtment of He	alth and M	ental Hygier	ne	
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П	Physici	ian	Decedent's Name (First, Middle, Last)	Δ.	00.	1		2. Date of Death Month	Day Year	3. Time of Death
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4	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death	' '	4c. County of Deat	h
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs	s. last birthday)	If Under 1 Year It	f Under 24 Hrs.	8. Date of Birth	HARTC 9. Birt	hplace (State or Foreign
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	shov	5	10d. State 10d. County	100.0	City, Town or Loc	a i i				10d. Inside City Limits 1 ☐ Yes 2 No
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ē	0 0		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crem	atory or other place)	land D 16	100		
Baltimore,	+ 문문를		21. Signature of Funeral Service License	<u>⊅</u> €1	H(() ()(No Dial Garo	of Facility 2 113	LIPART	Air M	EEST HILL,
ä	Departiment Department		minuted in //	Lautration						MD 21050.
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	Physician	O)	Immediate Cause (Final disease or condition			BLADDE			A	Onset and Death TWO VEARS
	/Medical Examiner		resulting in death)	Due to (or as a conse				•		, , , , , , , , , , , , , , , , , , , ,
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	entificating plans the as the	Med	IF FEMALE:							
Вох	eath certifi attending for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	aldeath 3 □i	Ectopic pregnancy			23d. Date of deli-	very Day Year
P.O.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5□	Other (specify)				,
	The law requires that the death cerif te has been signed by the attending tage 2 should be detached for use a	by Ph	Part II. Other significant conditions cor	tributing to death but not re	sulting in the un	derlying cause given ii	in Part I.	23e. Did tobacco	use contribute to	the cause of death?
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Division	l or Attending after death. Director: After I in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, stre		-	f. Location (Street a	and Number or Rui	ral Route Number.
D	elor A safter si Direct	Certification:	4 ☐ Homicide determined	building, etc. (Speci	ify)			City or Town, Sta	te)	
	To the Hospitel or, within 24 hours after To the Funerei Directorpletely filled in E	edical (29a. Certifier 1 Certifying Phys	sician: To the best of my kn	owledge, death	occurred at the time, o	date and place, ar	d due to the cause(s) and manner as	stated.
	the H the F the F	Medi		and manner stated.	ation and/or my					
	To To	~	29b. Signature and title of certifier	\mathcal{L}		29c. License nu			ate signed (Month,	
7	· M		30. Name and abovess of person who	mpleted cause of death "	m 02a) /5 0	aim t\		JU		
	37		ROBERTO PILIN	D. HOPKINS	CANCE,	R LENTER	1650 OR	LEANS STRE	EET RAI	TIMO RE MA
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			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
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			MARINER HEALTH OF 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	FOREST HILL If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye.	HARFOR 9. Birthp	D lace (State or Foreign try)
	Funeral Director			W 2, □ F 93 Yrs.	Months Days Hours Min.	Aug. 24 /	910 Perle	U S. s. A 11 B
	0		Usual Residence of Decedent	10c. City, Town or Lo	Scation	J	10	0d. Inside City Limits
	shov	č	10a. State 10b. County	1 Rolling	Δ			1 ☐ Yes 2 XiNo
	the N 28a-f	Funeral Director	10e. Street and Number	d I Del Ac	10f. Zip Code	10g.	Citizen of What Coun	try?
	3a or	D	1029 Alexandein	a Way	21014		USA	
	erne 2	iner	11. Marital Status	2. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
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	ould be fi Mental H arked otl atic ever	Ве	HPILDIL & MI	a Slope	Luna	GAIN	IDP	
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S	rs afte	Certification:	4 Homicide	building, etc. (Specify)		City of Town, 3	(4.6)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical		icien: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.				
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fre.	St	áte	31. Date filed (Month, Day, Year)	32. Registrar's Signature	COVINT TOO 1 WA	Trusto	19 - (1	- 10
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Amend item#1,PFR ME,C833,7/21/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 10, **Physician** 2004 Year Raymond N. Poteat, III 0210 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Unit block N. Carey Street Baltimore Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**∑** M 2□ F Maryland Director 14 Oct 14, 1989 218-25-8337 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County rel', or Items 23a or 28e-f shov Exertitier mast be notified at Yes 2 No Baltimore Funeral Director N/A Maryland 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "neturel; or items 23a or 2 any or other traumatic event, the Medical Engineer man U.S.A. 21223 17 N. Calhoun Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore City Schools College (1-4or 5+) Elementary/Secondary (0-12) Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond N. Poteat Jr. Virginia Sterrette ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 N. Calhoun Street Baltimore, Maryland 21223 Raymond N. Poteat Jr. Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ZION CEM 7/15/04 LANSDOWNE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gunshot wound of Head Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Ur denying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ sign be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 \sum No 24a. Was an autopsy performed? 2 🗌 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) At SCENE 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA 2 2 1 No this After thi 28a. Date of Injury Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural Injury 5 | Pending within 24 hours after death,

To the Funerel Director; Aft 1 ☐ Yes 2 No 10/04 investigation 2:07 AM subject shot 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Unit Block of N. (Avey St 3 Suicide 4 Homicide Baltimore H Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier llau md O.C.M.E. July 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1h 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

6 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** 7, William Poole July 2:45 a M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FutureCare Cherrywood Healthcare Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | Dec 31, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 219-05-5344 85 Maryland 1918 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28e-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2√ No Baltimore Reisterstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12020 Reisterstown Road or Itams 23a 21136 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Ital any injury or other traumatic event. It a Medical Exact 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates: white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) janitorial city of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Poole Pauline V. May 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Poole/son 823 S. Main Street Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4□Donation 5<u>XOt</u>her*(Specify)* in sta⁄te 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 irector 23a. Pan1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma **Physician** mo resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of) Examine Hospitel or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy should be detached for Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Hard Tillon 077802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coole O. Recharder, MAZIN 4. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

D	113		1 - For State Registrar	State of Maryland /	-	of Health a	nd Menta		000	\ !	00000
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Ball	permit. Pag Department Importent: any injury once.		21. Signature of Euneral Section Libense	50	22. Name and	Address of Facility		de>	Metre	Polit	en Chapel
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	0		30. Name and add ses of person who con			nn Street	, Baltin		Mary]		

			1 _ For State	State of Marylan	nd / Department of Certificate of		, ,	2001	22220
			Registrar 1. Decedent's Name (First, Middle, La	st)	Certificate	Dealii	Reg. No 2. Date of Death	2.004	3. Time of Death
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No.	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town	n, or Location of Death	7	County of Death	10,001,
			847 HERA	IDON COUR	TB	ROOKLY	N	BALTI	MORE
	Funeral		5. Social Security Number 6. S	6ex 7. Age (In yrs.	/ast birthday) If Under 1 Ye G Yrs. Months Day		8. Date of Birth (Month, Day, Year	9. Birthp	place (State or Foreign
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	or 28	Director	10e. Street and Number	1. 10	10f. Zip Cod	0	10g. Ci	tizen of What Cour	ntry?
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Ball	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service Licer	nsee	22. Name and Ad	dress of Facility BR	COWNIR	FUNER	The second second
	402 4 4		23a. Part1. Enter the disease, or com	plications that caused the death	Do not enter the mose of a	V. HULTON	AVE. BA	170, MD.	Approximate
			shock, or heart failure. List only	one cause on each line.	Latic La	,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence)	Tacc Mi	ng conc	CR		15 mos
	Examiner			Bila	teral Pi	ilmona	W Em	boli	2mos
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):		/		
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	sate be executed obysician and the burial-transit	E	resulting in dealin, cast	Due to (or as a consequ	uence of):				
687	B € €	dlcal		d					
Box (eath certific attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delive	rv
Ď.	death e atte	iclaı	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de					Day Year
P.0	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	9 🗆 Unknown	9LJ Unknown					
	es tha igned be del	by	Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlying cause	given in Part I.		use contribute to th	
ord	w requir	sted					10 Yes 2	□ No 3 □ Prob	ably 4 Unknown
3ec	e law has b	Completed					24a. Was an autopsy performed?	. prior to cor	osy findings available npletion of cause of
of Vital Records,			05 111				1□ Yes 2☑No	death?	2□ No
V.	Physicien: this certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	26. Place of Death	(Check only one) e 5 Residence	Δ Ποιτ /B/	
1 of	g Phy er this eral c	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In		e o Mescribe how inju		/
Division			1 Natural 5 ☐ Pending			Yes 2 No			
<u>:</u>	ath. er: Af	atlo	2 ☐ Accident investigation						
-	r Attending Fiter death. Irector: After Ire by the funera	tification				;e 2	3f. Location (Street and City or Town, State	nd Number or Rura.	l Route Number,
Ö	vitel or Attendir urs after death. ural Director: Al	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office		City or Town, State	»)	
Dİ	o Hospitel or Attendir 24 hours after death. Funeral Director: Al stely filled in by the fu		2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Accident 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify lysician: To the best of my knominer: On the basis of examinal	ome, farm, street, factory, office/y)	time, date and place, ar	City or Town, State	and manner as st	atad
ρ	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical Certification	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Exam	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office y) wledge, death occurred at the tion and/or investigation, in m	time, date and place, ar	City or Town, State	and manner as st	ated. the cause(s)
Div	or Ar	edical	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28e. Place of Injury - At he building, etc. (Specify lysician: To the best of my knominer: On the basis of examinal	ome, farm, street, factory, office y) wledge, death occurred at the tion and/or investigation, in m	time, date and place, are y opinion, death occurred	d due to the cause(s) at the time, date and	and manner as st d place, and due to	ated. the cause(s)
Div	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Af	edical	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28e. Place of Injury - At he building, etc. (Specify lysician: To the best of my knominer: On the basis of examinal and manner stated.	wledge, death occurred at the tion and/or investigation, in m	o time, date and place, ar y opinion, death occurred sinse number	City or Town, State and due to the cause(s) d at the time, date and 29d. Da	a) and manner as std place, and due to te signed (Month, 1	ated. the cause(s) Day, Year)
Div	To the Hospitel or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	28e. Place of Injury - At he building, etc. (Specify lysician: To the best of my known inner: On the basis of examination and manner stated.	wledge, death occurred at the tion and/or investigation, in m	o time, date and place, ar y opinion, death occurred sinse number	City or Town, State and due to the cause(s) d at the time, date and 29d. Da	a) and manner as std place, and due to te signed (Month, 1	ated. the cause(s) Day, Year)
Nig	To the Hospitel or Attendir within 24 hours after death. To the Funerat Director: After the Completely filled in by the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the funeration of the function	Medical	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	28e. Place of Injury - At he building, etc. (Specify lysician: To the best of my knominer: On the basis of examinal and manner stated.	wledge, death occurred at the tion and/or investigation, in m 29c. Lice 123a) (Type, Print) 5. Hamov	o time, date and place, ar y opinion, death occurred sinse number	City or Town, State and due to the cause(s) d at the time, date and 29d. Da	a) and manner as std place, and due to te signed (Month, 1	ated. the cause(s) Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per ft 8845 7-18-05 vt

			For	State of M		epartment of I		lental Hygie	ne	
			1 - State Registrar			Certificate of	Death	Reg.	No.2001	22330
П	Dhysisi		Decedent's Name (First, Middle, La	A				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		GEURGIANN	A AGN	ES IC	USH		5 1	7 2004	5:30 AM
)	Examir		4a. Facility Name (If not institution, given	,		4b. City, Town,	or Location of Death		4c. County of Deat	1
			Golden Age	GUEST H	ome	SYKE	SVILLE		CARRO	OLL
Г	Funeral				e (In yrs. last bir	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	9. Birtt	nplace (State or Foreign
н	Director		219 78 6079	1□M 2⊠F	87	rs. Worters Days	Tiours IMIII.	Nov. 21.	1916 mA	RYLAND
	pu ,		Usual Residence of Decedent		142 01 -					
	shov	_	10a. State 10b. County		10c. City, Towr					10d. Inside City Limits
	Ba-fa	양	mo CAR	NOLL	27	Kesuille				1 ☐ Yes 2 No
	다 다 6 2 2	- S	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	
	23a	ie i	6605 Mo.	NROE A	venue	21	784		U.S.	A.
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Madicel Examiner must be notilified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spensor Mexican Puerto	ecify Yes or No-	14. Race - Amer Black, White	ican Indian,
9	afte or It	五	1 ☐ Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give		1 ☐ Yes 2 ☑ No		110411, 010.)		, etc.
ğ	inal',	d by	3 Widowed 4 Divorced	Year or Dates:		12.00 20.10			Specify: W	hite
21215-0036	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a.	Decedent's Usual Occup (Give kind of work done	during most of worki	16b.	Kind of Business/l	ndustry
7	ithin Br	d d	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use retire	id)			
	filed w Hygien other ti	Ŝ	(1			Homemo			WN HO	me
בַ	be first H d off	Be	17. Father's Name (First, Middle, Last				A	(First, Middle, Maid	,	
<u> </u>	should ind Men marke umatic	မ	George W				Anna	R. Gr	eenWA	LT
Maryland	2 sh and is m		19a. Informant's Name/Relationship (7 / 1		Mailing Address (Street	1.047			
	and ealth m 27 ner tr		CAMPION W. Ru	sh/ Husb		05 MONR	oe Ave.	1.100.	lle, mo	21784
ore	of H of H if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Bemoval from State	20b. Place of cemeter	Disposition (Name of crematory or other pla	ce)	ate 20c.	Location - City or T	own, State
Ĕ	Pages nent of ent: If it ury or o		`4 □Donation 5 □ Other (Special		LAKell	Iew mem 1	OK 7/16	104 5	ykesvill.	e, MO
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at one.		21. Signature of Funeral Service Lice			22. Name and Addre	ess of Facility	ZUMBRU	NFIH. 8	MON. Co.
m	8 9 5 8 8		Jeffy N. Su	mbrun		6028 5	1Kes Ville	Rd. EL	DensRian	6 mo 21784
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do n	ot enter the mode of dyin	ng, such as cardiac o	r respiratory arrest,	0 (113)	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final			- 2-11-				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence of	T DEMENTA	A			KIYR
	Examiner			Due to (or as	a consequence o	r):				
		ē	Sequentially list conditions, if any, leading to immediate gauss. Enter Underlying	b. — Due to (or as	a consequence o	n:				
	unsit	Examiner	Cause (Disease or injury							
_	and altra	xa	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	f):				
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit									
387	ficate phys	edlcal		_ d						
_	ding	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					
Вох	leath certi attending I for use a	iar	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of deliv Month	ery Day Year
o.	he d the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	time or death	5 □ Other (specify) _				
Δ.	res that the de signed by the a be detached f	by Physician/M	Part II. Other significant conditions of	contributing to death b	ut not resulting in	the undertying cause an	en in Part I	23a Did tobacco	use contribute to t	he sauce of death?
Records,	signe signe d be	ğ	BLADDER C		at Hot 150aking in	and andonying dadso giv	on are are.			pably 4 Unknown
Ö	w require been si should b	etec	1001.141					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 NO 3 FIO	Jabiy 4 Onknown
ec	e law has t	ם						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	Physicien: The this certificate har director, page	Completed						performed? 1 ☐ Yes 2 ☐ K	/ death?	210No
Vital	or Attending Physicien: Thater death. Director: Atter this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
	Physic this o	ပ္	1 ☐ Yes 2 ☐ 10	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3 DOA Oth	er: 4 Nursing Hom	ne 5 Residence	6 □Other (Specif	(y)
C	ng P fter t		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day		me of 28c. Injur		8d. Describe how inj		
Ö	death. ctor: A r the fu	ate	2 ☐ Accident investigation	1			Yes 2 □ No			
Division of	I or Attend after death Director: ,	ijI	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, fari	n, street, factory, office	2	8f. Location (Street a	and Number or Rure	I Route Number,
	tal or A s atter el Dire ed in by	Certification:			(-,,)			,	10)	
	Hospital 24 hours 2 Funerel I		29a. Certifier 1 Certifying Ph	ysicien: To the best o	of my knowledge,	death occurred at the tin	ne, date and place, a	nd due to the cause(s) and manner as s	tated.
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	one)	and manner sta	examination and	or investigation, in my o	pinion, death occurre	a at the time, date a	nd place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	_ /	DIA.	29c. Licens	e number	29d. D	ate of gned (Month,	Day, Year)
	1		+ATRICK I	URNES/9	allelo	ullan D7	20806	7	1/14/2009	1
	10		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)			1:1201	
	V		PATRICK TURNES	100	O LIBO	CTY ROAD	ELDORS	BURG A	10 21:	784
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	17			-1 (-/-
	Registra	ar	IIII 1 6 200	A Real	H.	lacett .				

		•	FOI	partment of Health and Me partificate of Death	ental Hygier	2001 000
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Annie Mae Roberson	J	uly 12	2004 Year 11:10p
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			7 Strut Court	Middle River		Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday 1. Age (In yrs. last birthday 85 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea	
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be nutified at	5	MD Baltimore			1 ☐ Yes 2x No
	28a-	Director	10e. Street and Number	Middle River	10g. (Citizen of What Country?
	h with	ai D	7 Strut Court	21220	U	SA
	r deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
8	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be nutified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give ③ C□ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		SpecifyWhite
9500-c	e hours		15. Decedent's Education 16a, Dec	edent's Usual Occupation	16b.	Kind of Business/Industry
212	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)		
N	filed wit Hygiene other the	Соп	11th Hom	emaker		wn home
and	be file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (en Sumame)
Š	s 1 and 2 should be f f Health and Mental I fem 27 is marked or other treumatic eve	ပ္	SAM Lee Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Ella Ra ling Address (Street and Number or Rural R	-	y or Town State Zin Code)
<u> </u>	treui			0 Ladoga Lane Ne		
ā,	s 1 ar f Hea stem 3			position (Name of Date ematory or other place)		Location - City or Town, State
Ê	Page nent o nt: If			onCemetery 7/17/	04 Wo	olwine VA
Baitimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Con 300 Mace Ave.	nellyFu	neralHomeofEssex
			23a. Part1. Enter the disease, or complications that caused the death—Donot er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	M CO Λ		Onset and Death
	/Medical Examiner		resulting in death) a. Due to or as a consequence of):			
	Examine	_	Sequentially list conditions, if any, leading to immediate			
T	ted nsit	nlne	Cause (Disease or injury			
,	execu n and ial-tra	Examine	that initiated events compared to the control of th			
3/60	certificate be executed ding physician and use as the burial-transit	dlcal	d			
9	rtifica ng ph		IF FEMALE:			
X Q Q	death certifica e attending ph ed for use as t	ician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
- -	0 0	Physic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		
7.	requires that the de een signed by the a hould be detached I	y Ph	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ras,	0 D	ed by			1 🗆 Yes	2 □ No 3 □ Probably 4 ☑ Soknown
Vital Record	> 00	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ř	The ate h page	mo:			performed?	death?
<u> </u>	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
0	Phys this al dii	7 L	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27Wanner of Death 28a. Date of Injury 28b. Time		d. Describe how in	6 □Other (Specify)
	ling After une	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	a. Describe now in	ury occurred
DIVISION	of or Attending after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si			and Number or Rural Route Number,
	i Site	Certification:	4 ☐ Homicide determined building, etc. (Specify)	T.	City or Town, Sta	ite)
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal one) 2 Medicel Examiner: On the basis of examination and/or in analymanner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. E	Pare signed/(Month, Day, Year)
			> Makua Sun	2052055	7	112104
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) CACOLA 2 ROL	13/167	140RF 21220
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	1000 -11	
	Registr		JUL 1 6 2004 Seleva B	spoils		

			For State Registrar	State of Ma	arylan	-	artment of H		and M		ene ()	04	223	132
	Diam'r.		1. Decedent's Name (First, Middle,							2. Date of Death	Day	Year	3. Time	of Death
	Physicia /Medic		Anna	L.		Robe				7	13	2004	8:2	м q0
	Examin	er	4a. Facility Name (If not institution,		- 10	M2	4b. City, Town, or	Location of timor			4c. Cou	nty of Death		
	Funeral		1600 Mt. Roya 5. Social Security Number		t. 10	ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,			lace (State	or Foreign
	Director		215-18-9316	1□M 2X F 9	3	Yrs.	Months Days	Hours	Min.	6-11-1	Year)	Coun	Md.	
	Pu ≥ !!!		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ocation					1	Od Inside	City Limits
	Aaryla r sho	ō	Md. N	Α			timore					1		s 2 No
	28a-	rect	10e. Street and Number				10f. Zip Code			10	g. Citizen	of What Coun	itry?	
	h with	o le	1600 Mt. Royal	Ave. Apt	. 100)2	2121	7			U	JSA		
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?			Was Decedent of H		gin? (Spe	city Yes or No- Rican, etc.)		Race - Americ		
36	or It		1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	id 1 ⊟Yes 2 🔼 If Yes, Give	No		1 ☐ Yes 2 🛣 No	Specify:		,			ack.	
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Evambar must be multihed at	ed b	15. Decedent's	Year or Dates:		16a, Dece	dent's Usual Occup	ation			6b. Kind of	f Business/Inc		
715	nin 72 nn "ne Medic	plet	(Specify only highest Elementary/Secondary (0-12)		5+1	(Give	kind of work done of DO NOT use retired	during mos	t of worki	ng			Juony	
	giene giene er the	Completed by	9th grade		,,,]	Domestic					Peopl	e Hon	nes
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Items 23e or 28a-1 show entry or other traumatic event, the Medical Examinational Legisland and once.	Be	17. Father's Name (First, Middle, L. Dennis		Brook	s			r's Name arri	(First, Middle, N ette		_{ame)} Musehe	tte	
ary.	should nd Me mark mark	ဥ	19a. Informant's Name/Relationshi				ng Address (Street	and Numbe	or or Rura	l Route Number,	City or Tov	wn, State, Zip	Code)	
	and 2 alth a 27 le		Marlene Brammer	Daug	hter	740 (Camberley	Circ	le A	pt. a_6,	Balt	imore,	Md.	21204
Baltimore,	of He of He if item or oth		20a. Method of Disposition 1 Burial 2XI Cremation	3 □Removal from State	CE	emetery, crei	sition (Name of natory or other place	e)				n - City or To	,	
ţ	t. Pag rtment rtant: njury		`4 ☑D nation 5 ☐ Other (Spe	ecify)	Gre		int Cem.	4 F* 1814	7-16			imore,	Md. 21202	,
Bal	Departiment of the permit of t		21. Signature of Funeral Service Li	2. Wat	ters		Name and Address March F.H					th Ave		4
			23a Part . Enter the disease, or of shock, or heart failure. List o	omplications that caused nly one cause on each ti	the death	Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arre	st,		Approximation Interval Bi	etween
k	Prysician		Immediate Cause (Final dis a F or condition resuling in death)	_ a	500	hoza	2) Conce	4				- 4	7 mon	16
	/Medical Examiner		1650 mily in doubly	Due to (or as	a consequ	ience o								
	. *	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ience of):								
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
ó,	e exec ian ar urial-ti	I Exa	resulting in death) Last	Due to (or as	a consequ	ience of):								
8760,	ficate be executed physician and s the burial-transit	dical	'	d										
9 X	death certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. [Date of delive	rv	
Вох	death certif e attending id for use as	Iclar	in the past 12 months?	t ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)						Day	Year
Ö.		Physician/Me	9 Unknown	9∐ Unknown										
ds, P	es ign	by	Part II. Other significant condition	s contributing to death b	ut not resu	ilting in the u	nderlying cause give	en in Part I.		23e. Did toba	_/	ontribute to th		death?
Records,	> Q S	ompleted								24a. Was an	241	b. Were autop	sv finding	s available
Re	The law ate has b page 2 si	duic								autopsy	ed?	prior to con death?	nplation of	cause of
Vital	ician: Th certificate rector, pag	O	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes 2)	1 L Yes	2/ No	
f Vi	di is	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatie	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Oth	200	rsing Hon			Other (Specify)	
n of	ding Pt		27. Manyer of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Worl			28d. Describe how	v injury occ	urred		
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Division	of or Attendated after death	Certification;	4 Homicide determin	building, et			eet, factory, office			28f. Location (Str. City or Town,	State)	mber or Hurai	House Nu	трөг,
	Hospite 4 hours Funerel ety fille	ledical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner sta	f examinat	wledge, death ion and/or in-	n occurred at the tin vestigation, in my o	ne, date and pinion, dea	d place, a	and due to the cared at the time, da	use(s) and i	manner as sta e, and due to	ated. the cause	(s)
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	. (.		1 P Kuri	_			Da	4321	/		1/14	404		
	X		30. Name and address of person w	to completed cause of d			Print) W St. 1	3a141	nora	mo	212	201		
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	Registr		JUL 1 6 2004	Derey	100	14	pals							

			1 - For State Registrar	State of M	Maryla		artmen rtificat			and M	lental H	ygien Reg. M	MA	L ,	223	33
п	Physic	ian	1. Decedent's Name (First, Middle, I	,							2. Date of D	eath		Year	3. Time	of Death
	/Medi		Nellie	Sue		Ro					July 1	. , 20	04		1:40	Р м
	Examir	ner	4a. Facility Name (If not institution, g						Location of	f Death			c. County o			
			Bradford Oaks N 5. Social Security Number 6			- / history	If Under	into	n If Under 2	17 Uro			rince			
	Funeral Director		414–48–1971 Usual Residence of Decedent	1 □ M 2XOXF	7:1	s. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of B Month, 1 01/22	193	3 1	9. Birthpl Count enne	ace (State try) SSEE	or Foreign
	the Maryland r 28a-f show	Director	10a. State 10b. County 10b. County 10c. Street and Number	George's	1	oity, Town or Lo Oxon Hi		Code				10a C	itizen of Wi			City Limits
	3a or		5007 Chester St	reet					745			US		iat Couri	uy:	
9800	s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdcal Entra naturals be notliged at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🏋 🛣 ivorced	12. Was Deceder Armed Force: 1 Yes XI If Yes, Give Year or Dates	s? ⊈No		Was Deced If Yes, spec			gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		14. Race	, White, e		
21215-0036	vithin 72 t ne. han "natu e Meo ca	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4o	r 5+)	16a. Dece (Give life.	dent's Usua kind of woi DO NOT us	rk done d se retired	ation Juring most)	of worki	ng		(ind of Bus		•	
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Jar	12 sh and ris m		19a. Informant's Name/Relationship								l Route Numi			tate, Zip (Code)	
	1 and 2 Health tem 27 i		Mary Sue Banning	/ Daughte		3 Ros	Sewood	1 St	. F <u>al</u> r		h, Vir			2405		
ğ	ages nt of t: if it		1 ☐ Burial 2 🖾 Cremation 3		e Ka	Place of Dispo cemetery, crei las Cre	natory or of	ther place	9)				ocation - C	•		1
Baltimore,	permit. Pages 1 and 2 Department of Health & Important: If Item 27 ti any injury or other tra ance.		 4 □ Donation 6 □ Other (Spec 21. Signature Funeral Service Lic 		I Ra						/2004			r, M	aryla	nd
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,8760,	death certificate be executed et attending physician and et for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a												
O. Box 6	0 5 9	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fet	al death 3 □	Ectopic pre						23d. Date o		,	Year
rds, P	9 Ped	by	Part II. Other significant conditions	contributing to death	but not re	sulting in the ur	nderlying ca	use give	n in Part I.				use contribu		cause of c	
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Ξ	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		35000		Otho			(Check only					
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=	a trice	Certification:	3 Suicide 6 Could not determined		ijury - At h itc. <i>(Speci</i>	nome, farm, stre fy)	eet, factory,	office	-	2	8f. Location (City or To	Street an wn, State	d Number (or Rural I	Route Num	ber,
	To the Hospital within 24 hours a To the Funeral C completely filled it	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	JI UXAIIIII	owledge, death ation and/or inv	occurred a estigation,	t the time	a, date and nion, death	place, a	nd due to the d at the time,	cause(s) date and	and manne place, and	er as stat I due to th	ed. ne cause(s)
	To the To the comp		29b. Signature and title of certifier				29c.	License	number 19431				e signed (A		ay, Year)	
	W		30. Name and address of person who Frank M. Ryan	completed cause of Md 11	death (Iter	m 23a) (Type, I Livings	rint)				Washir		1, 2		ıd ′	20744
	Sta	te ar	31. Date filed (Month, Day, Year)	.32. Regist	rar's Signa	ature	Sou K		,, 100		WOIIII.	ig LUII	, rai	yrall	IU 2	20/44

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Francis M. Reilly, Jr. July. 2004 10:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 774-B Fairview A<u>venue</u> Annapolis Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Director 077-14-1074 83 Sept.1,1920 <u>New York</u> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow irel', or Items 23a or 28a-f ehov Examiner must be notified at Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 774-B Fairview Avenue 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1942–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed permit. Peges 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natur any injury or other treumatic event, Ite Medical page. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Photo Interpreter Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis M. Reilly Anne Gertrude Lawlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura T. Reilly/Wife 774-B Fairview Ave. Annapolis, Md. 21403 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 7-12-04 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licens 22. Name and Address of Facility George F. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md.21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician myourndipe INFARCTION resulting in death) /Medical Due to (or as a consequence of): Examiner GUNGETIVE HEART PALLYNG Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien a ned for use as the burial-P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATMAL FIBRILATION certificate has autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signatule and titl 29d. Date signed (Month, Day, Year) HOU566 19 Û no addre s of person who completed ause of death (Item 23a) (Type, Print) 30. Name 32. Registrar's Signature Medical PKWY Suite TOTRICK CAI State JUL 1 6 2004 Registrar

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			for State	Slai	e oi ivia	iylanc		rtificate of		u Mentan	Reg. N	office of the	01	20005
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	Funeral			S. Sex	7. Age	(In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of	Birth Day, Yea			ace (State or Foreign try)
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	land		Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Lo	ocation					10	Od. Inside City Limits
	Mary -f sh	ţō	Maryland Anne	Arunde	1	Page	adena							1 ☐ Yes 2 🔀 No
	h the	Director	10e. Street and Number	AI unuc.	<u> </u>	1 (1/3)	Idena	10f. Zip Code			10g. C	itizen of	f What Coun	try?
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	tems	nue	11. Marital Status	Ame	Decedent E		. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin oan, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-		ace - America ack, White, e	
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show he Medical Examinar must be notified at	Completed by Funeral	15, Decedent's (Specify only highest	Education			16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation	wadina	16b.	Kind of	Whi Business/Ind	
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	0 0 2 6		Neil A. Ridgell	Jr.	(Son)		1402	Old Fort	Smallv	vood Road	l Pas	ader	na. Ma	ryland 2112
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr onca.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	Removal	from State	20b. Pla	nce of Dispo metery, crei	sition (Name of matory or other pla	ice)	Date	20c.	Location	- City or To	wn, State
Ë	Pant ant		* 4 □ Donation 5 □ Other (Spe	ecify)		Bay		Cremator		16/04				aryland
Salt	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Li	censee			Mo	Cully-Po	ess of Facility Syniak	Funeral	Home	, P.	. A.	
	0.0 = 6 0		222 Part Enter the disease or o	6-14	that caused i	the death	Do not ent	204 Mount	ain Roa	d Pasade	ena,	Mary	yland	21122 Approximate
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rds	v require been sig should b	ed b	RENAL F	-AILU	RE					1	☐ Yes 2	2 □ No	3 🗌 Proba	bly 4 Onknown
Records,	law requ as been 2 should	Completed								24a. W	as an topsy	24b.	. Were autop	sy findings available
		Com								pe	rformed? 2 ☑ N		death? 1 ☐ Yes	
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of	Physic this cral dir	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 Inpatient Date of Injury		P/Outpatien 28b. Time of			ng Home 5 Re				
on	fte	tlon	1 Natural 5 Pending 2 Accident investiga		(Month, Day	Year)	Injury	Wo	rk?]Yes 2 □ No	200. Dogone	o now my	ny occu	iii 6u	
Division of Vital	Atten r deal ector: by the	Certification:	3 Suicide 6 Could no determin	t be 28e. I	Place of Inju	ry - At horr	ne, farm, str	eet, factory, office		28f. Location	(Street a	nd Num	ber or Rural	Route Number,
Ö	s afte	Cert	4 Homicide		building, etc.	(Specify)				City of	rown, Stat	θ)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1	kaminer: On	o the best of the basis of manner stat	examinatio	ledge, death on and/or in	n occurred at the ti vestigation, in my	me, date and pl opinion, death o	ace, and due to the courred at the time	ne cause(s e, date ar	s) and m	nanner as sta , and due to	ted. the cause(s)
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_	1)		30. Name and address of person w	NI				Print) RUND	EL H	OSPITI	¥L.	٨	ND 2	1061
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			1 - For State Registrar	State of Maryland / [Department of H Certificate of L			65 65 45 E	
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeani	2. Date of Dea	ath	3. Time of Death
	Physicia		ALBERT	RITTER			Month	Day Year	6:3814 M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or	Location of Deat		4c. County of Dear	h
			FRANKLIN	JGUARE H	OST KO	sedal	e	BALT	IMORE
	Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	y Year) 9. Bird	hplace (State or Foreign untry)
			Usual Residence of Decedent	10			HLIC'T!	21724 (32)	ZU/HUA
	arylan show		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	he Ma 188-f	Director	WHOSTERD HEREO	50 82	LHIR				1 ☐ Yes 21€ No
	with the or 3	Dir	10e. Street and Number	A-11 0000	10f. Zip Code	200		10g. Citizen of What Co	untry?
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ထ္	or ite	Fur	1 Never Married 25 Married	Armed Forces? 1 ☐ Yes 255 No If Yes, Give	If Yes, specify Cuba	n, Mexican, Puer Specify:	to Hican, etc.)	Black, Whit	e, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28a-f show the Macical Examiner must be mailfied at	d by	3 Widowed 4 Divorced	Year or Dates:			· · ·	u	nite.
7	in 72 n *nat	Completed	15. Decedent's Educi (Specify only highest grade	completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	luring most of wo	rking	16b. Kind of Business	industry
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b	be file tal Hy d othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Sumame)	
yla	Meni Meni Marke	ပ	ERICH K	TTER		57:56	HTZCV	FINK	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23e or 28a-1 show amprortant: If item 27 is marked other than a natural, or itema 23e or 28a-1 show any figury or other traumatic event. The Marcial Examination at the notified at ODGs.		19a. Informant's Name/Relationship (Typ	9, <i>Print)</i> 190	. Mailing Address (Street a	Acai O	ural Houte Numbe	r, City or Town State, 2	(1) (code) 1,1379
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Place of	Disposition (Name of		Date	20c. Location - City or	Town, State
Ë	Pages lent of nt: If i		1 ☐ Burial 2 A Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	ry, crematory or other place	De 7-	15-04	Forest H	11 mb
Baltimore,	rmit. spartm porta ny inju		21. Signature of Funeral Service License	0 1	BECAIR- FUNGLAL (HA 22. Name and Addres	s of Facility 3	VEWPOR	ET DR. FOI	REST HILL
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		skar Vascu	cork.	DISEASE		
60,	icate be executed physician and s the burial-transit		Tossiting in doutin, East	Due to (or as a consequence	01):				
68760		edical	d.						
Вох	death certifi e attending I od for use as	m/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy			23d. Date of del	very
о В	0 0 0	Physician/M	in the past 12 months? 1 Yes 2 No	4 Pregnant al time of death	5 Other (specify)			Month	Day Year
P.O.	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions cont		the underlying cause give	on in Part I	23e Did to	bacco use contribute to	the cause of death?
Records,	50 00	d by	RENAL R		The underlying cause give	or irr arti.		es 2□No 3□Pr	-
COL	w require been si should b	lete					24a. Was a	an 24h Were au	topsy findings available
Re	o - o	Completed					autop perfor	sy prior to	completion of cause of
	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical			26. Place of De	1 ☐ Yes ath (Check only or		2 140
oţ <	Physician: this certificant	To	TIL Tes ZIANO					ence 6 □Other (Spe	cify)
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	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier 12 Certifying Physic (Check only one) 2 Medicel Examin	ician: To the best of my knowledge er: On the basis of examination an and manner stated.	e, death occurred at the time d/or investigation, in my op	e, date and place pinion, death occu	e, and due to the curred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	ro the	Med	29b. Signature and title of certifier	and mannor stated.	29c. License	number	2	29d. Date signed (Monti	n, Day, Year)
}	7		1 Doeu	ND	055	306		7/15/04	+
	X		30. Name and address of person who cor			r€ 303	BALTO	ND 112	3.7
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 6 2004	32. Registrar's Signature	Souls				

				Please	State of Mai				l Copies Are lental Hygier	•	
				1 - For State Registrar	Otate of Mai	•	rtificate of		Reg. N	0 0	0000=
				Decedent's Name (First, Middle, Last,)				2. Date of Death	Day Year	3. Time of Death
0		Physici /Medio		Clarence Reed					July 6, 2	2004	8:05 AM M
0	4	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	4	c. County of Death	
3				Harford Memoria 5. Social Security Number 6. Se		L (In yrs. last birthday)		de Grace	8 Date of Birth	Harfo:	nd
22		Funeral Director			7	8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea June 23,	1936	place (State or Foreign intry) unk
9				Usual Residence of Decedent							
3		arylar show	7	10a. State 10b. County MD Harford	1	10c. City, Town or L Aberde					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
3		with the Maryland a or 28e-f show	ecto	10e. Street and Number		Abelde	10f. Zip Code		10n (Citizen of What Cou	
a		with 3a or	וסו	8 South Parke St	reet		,	.001			,
T		172 hours after death with the Maryla "natural", or Items 23a or 28e-f shor ratical Exercitive inveloe at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.		Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Amer Black, White	
,	9	after or its		1 X Never Married 2 ☐ Married	1 X Yes 2 ☐ No		1 ☐ Yes 2 No		nican, etc.)	Specify: Wh	
05	21215-0036	72 hours after natural', or its doal Exercitive	d by	3 Widowed 4 Divorced	Year or Dates:				11mle 10h		-
0	15-	in 72	olete	15. Decedent's Edu (Specify only highest grad	te completed)	(Give	edent's Usual Occup is kind of work done DO NOT use retire	during most of worki d)	ng UIIK 160.	Kind of Business/I	ndustry unk
00	212	d within piene. r than "	Completed	Elementary/Secondary (0-12) unk ur	College (1-4or 5+)					
	altimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 le marked other than any injury or other treumatic event, ITE Magnee.	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	(First, Middle, Maide	en Surname)	unk
4	ary	shou and N e mar	_	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mail	ing Address (Street	and Number or Rura	I Route Number, City	or Town, State, Z	ip Code)
0	Σ	and 2 ealth m 27 i		Harford Memorial	Hospital		S. Union		vre de Gra		
19	Ore	ges 1 It of H If itel or off		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Disponentery, cre	matory or other pla	ice)	Date 20c.	Location - City or 1	own, State
10	I i	il. Pa rtmen rtent: njury		* 4 □ Donation 5 ☒ Other (Specify)		/	2 Name and Addrs	ess of Facility			
1	Ba	permi Depa Impo any ir		21. Si viature of Funeral Service Licens	Wade Dyr	ctor S	tate Anat	Tomy Board	655 W. Ba	altimore	Street
				23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to	he death. Do not en	ter the mode of dyi	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	, B	Physician		Immediate Cause (Final disease or condition	· VV	muic o	LICTVIK	Sive P	ulmonary	divers	Onset and Death
	4	/Medical		resulting in death)	a. Due to (or as a	consequence of):	33,70	0 1	Virteressi) Livra	,
	10	Examiner		Sequentially list conditions,			ive ha	art-fail	ure		10 years
		ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					215
		e be executed rsician and e burial-transit	xan	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
2	68760	e be exergician are burial-t	cal		d						
0.0		w requires that the death certificate been signed by the attending phys should be detached for use as the	Jedi	IC CCMALC.							
7	Вох		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1□Live birth 2	☐Fetal death 3	□Ectopic pregnanc	ty .		23d. Date of deliver Month	very Day Year
1	.O.	ne dea the at hed fo	sicl	1 Yes 2 No	4□Pregnant at ti 9□Unknown	me of death 5	Other (specify)				
3	<u>α</u>	The law requires that the death tte has been signed by the atter age 2 should be detached for u		Part II. Other significent conditions co	ontributing to death but	not resulting in the u	undertying cause giv	ven in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
7	Vital Records,	uires sign ld be	d by						1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
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0	Re	The la te has age 2	E O		- to the total or				autopsy performed?	death?	
3	ital	<i>ia □</i>	BeC	25. Was case referred to medical				26. Place of Death			
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eed,	D C	ding Physicien: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo		28d. Describe how in	jury occurred	
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3/5A		To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C		ysician: To the best of iner: On the basis of and manner stat	examination and/or in					
21)		To the within To the comple	Med	29b. Signature and title of certifier			29c. Licen:	se number	29d. D	Date signed (Month	, Day, Year)
				1 CM Or	MD		Po	003671.	5	7	804
_				30. Name and address of person who o	•	ath (Item 23a) (Type	, Print))	8 04 GRACE MD
				5 HeRJ F OS 31. Date filed (Month, Day, Year)	MAN 32. Registrar	M, D. C	015	UNION	AVE H	Avrede	GRACE MD
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State

Registrar

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Northwest Bospital Function Director D	Time of Death
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause on each line shock or heart failure. List only one cause oripury listed that all the subtribute of the cause of the failure	d. 2121 tate
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Sproop of the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery 1 Yes 2 No 9 Unknown 23d. Date of delivery 23d.	oximate val Between and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II. 23e. Did tobacco use contribute to the cause given in Part II.	Year
24a. Was an autopsy find autopsy performed?	se of death?
The second of th	on of cause of
O 5 5 5 7 1 27 Manuary Ports	e Number
The state of Injury at Inj	
1 Jogina 1 11 tales mo Doo 41410 July 13th, 200	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER PMEHTA NEATHNEST HIS PIAM CENTER RANGUSTOWN MD 31133 State Registrar JUL 16 2004 JUL 16 2004 JOGNACO	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) MONROE 2. Date of Death STANFORD **Physician** $^{\text{Da}}2004^{\text{ Year}}$ July 7, 15:27 М /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical Syst. Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral XXM 2□F 217-60-1910 51 Director Feb. 4, 1953 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "naturel", or items 23a or 28a-f shov If a Medical Examiner is ust be institled at Maryland N/A Baltimore 1 √ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5608 Stonington Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after Yos 2□No Viet 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1☐Yes XXXX If Yes, Give Year or DatesNam Era Specify: Specify: Black be filed within 72 hours all Hygiene.

I other then "naturel", \$ 3 ☐ Widowed 4 ☐ Pivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Town and Country Elementary/Secondary (0-12) College (1-4or 5+) Building Maintenace Apts 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic events. Milford Stanford Mabel Smith is marked 19a. Informant's Name/Relationship (Type, Print) 2058 Linden Avenue Baltimore, Maryland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Burkett/ Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/12/04 t. Cem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Owings Mills, Md 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Exmeral Service Licensee Pla 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Hemorrahage /Medical Due to (or as a consequence of): Examiner Thoracic Abdominal Aortic Aneurysum Rupture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death signed by the a 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes XX No 24a. Was an cate has page 2 s autopsy performed?

1 Yes XX No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 XNo this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Watural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 / Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of cortif 29c. License number 29d. Date signed (Month, Day, Year) D60573 July 13,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Masser Bade, MD 22 S. Greene Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 6 2004 oals Registrar

			1 - For State AMEND ITEM	State of M	aryland / Dep	artment of H	lealth and	Mental Hy	giene	71.	2221
	Physic	an	1. Decedent's Name (First, Middle, La					2. Date of De	eath Day	Year	3. Time of Death 4:51PM
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City, Town, or Bac	Location of Deal		4c. County	of Death	4:311
	Funeral Director		5. Social Security Number 6. S 217-24-2854 1 Usual Residence of Decedent	ex 7. Ag	ge (In yrs. last birthday 74 Yrs.		If Under 24 Hr. Hours Min	S. 8 Date of Bir	th Year) 29, 1929	9. Birthpla Countr Mary	ice (State or Foreign Land
	deeth with the Maryland ms 23a or 28a-f show rmust be notified at	ctor	10a. State 10b. County Maryland Frederi	ck	10c. City, Town or L Frederic					10	d. Inside City Limits
	th with the 23e or 28 vet be no	al Director	10e. Street and Number 8408 Williams	Drive		10f. Zip Code 21704	4		10g. Citizen of V U.S.A.	Vhat Countr	y?
900	ours after rat', or ite	t by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 13. No 1948–1956	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	ispanic Origin? (! n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - America ck, White, et :: White	tc.
Maryland 21215-0036	be tiled within 72 hours after ital Hygiene. dother then "natural", or ite event, the Medical Evamina	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or: 2	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of wo		16b. Kind of Bu		
yland	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) Robert Leonard	Smith, Sr	•		18. Mother's Na	me (First, Middle,		re)	
	es 1 and 2 should be of Heelth and Ment of Item 27 is marked rother traumatic e		Mrs. Ida M. Smith	** '	840	ng Address <i>(Street a</i> B Williams	and Number or R	Frederi	ck, Mar	yland	21704
Baltimore,	Pag nent ent: i		20a. Method of Disposition 12 Surial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	")	Parkwood M	psition (Name of matory or other place EMORIAL CEME	etery Jul	y 14, 2004	20c. Location - Baltin	City or Tow	n, State MD
Bal	permit. Departr Import any inj		21. Signature of Funeral Service Licen		M00255	Keeney and 106 East (Church S	t., Fred	lerick, l	me MD 21	1701
	Physician /Medical Examiner		23a. Part1. Enter the disease, br com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_	a consequence of):					l Ir	Approximate nterval Between Onset and Death
90,	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):						
68760,	rtificate be ei ng physicien as the buria	Medical	IF FEMALE:	d						.	
P.O. Box	requires that the death certificate be execui een signed by the attending physicien and nould be detached for use as the burial-trar	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth D	
Records, F	w requires that been signed to should be deta	ted by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco use contri es 2000		cause of death?
al Reco	The taw ate hes b page 2 st	e Completed	25 18					24a. Was autop perfo 1 🗆 Yes	rmed? d	rior to comp eath?	y findings available eletion of cause of
Division of Vital	hys this	ToB	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time o	28c. Injury Work	r: 4 ☐ Nursing H	ath (Check only of dome 5 Residence 128d. Describe h		er (Specify) ad	Hospital
Divis	itel or Attencrs efter death rs efter death ef Director: led in by the l	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Numbe n, State)	or Rural R	Route Number,
	To the Hospitel or Attending F within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	Medical	one)	raiciam: To the bast iner: On the basis of and manner sta	of my knowledge, deal examination and/or in ated.	vestigation, in my op	inion, death occu	irred at the time, o	date and place, a	nd due to th	e cause(s)
	To with	2	29b. Signature and title of certifier Western 30. Name and addre, s of person who c	L. Mul	Our	29c. License	number 76435		29d. Date signed	(Month, Da	y, Year)
	15	10	Meghan L. Mill 31. Date filed (Month, Day, Year)	er, M.D.,			Baltimor	e, MD 21	201		
DH	Sta Registr	ar	JUL 1 6 2004	Bree	a la	Spark					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:30 P M 07 MARGARET STERSHIC 2004 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD 8. Date of Birth (Month, Day, Aug. 8, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Min. Days Hours 1 □ M 2 🛛 F 81 1922 195-12-9171 Yrs. Pennsylvania Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental Hygiene.
ant: If item 27 Is marked other then "naturel", or items 23a or 28a-1 ehov ury or other traumatic event, the Medical Examination and be stuffled at 1 ☐ Yes 2 No Maryland Baltimore Kingsville Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11200 Towood Road 21087 u.s.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andro Kovalic Anna Petro 19a. Informant's Name/Relationship (Type, Print) (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Stershic, Jr. 11200 Towood Road, Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Important: eny injury o Parkwood Cemetery 7/17/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes once 9705 Belair Rd., Baltimore, MD 21236 al Queu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OBSTRUCTIVE ears resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? . 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Nypothyroldism 1 🗌 Yes 2 🗌 No Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 certificate rchal depression 0000 1 Yes Division of Vital Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ Yo Hospital: Other: 3 DOA Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Inpatient 2 ER/Outpatient 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 TYes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital or Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who co mpleted cause of death (Item 23a) (Type, Print) KMAN R. STANLEY 308 Isiness Cte Wa 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 6 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** 2004 William Kemp Schwarzel 2:30 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HARFORA If Under 24 Hrs 8. Date of Birth (Month, Day, Y Oct. 10, If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1₽M 2□ F 219-28-1174 72 Yrs Oct. Ĩ/931 Maryland Director Usuel Residence of Decedent filed within 72 hours efter daath with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If them 27 te marked other than "naturel", or theme 23s or 28s-f eho Injury or other traumatic event, the Madical Examinar must be nortified at Md. **Baltimore** Baltimore 1 ☐ Yes 2X No **Funeral Director** 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 4233 Soth Avenue 21236 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: white Specify: Be Completed by 3 XWidowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) soap manufacturer 6 years <u>laboratory</u> technician 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h end Mentel H Pages 1 end 2 should be William Schwarzel Anna O'Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) them 27 to Lisa Anne Kraus/daughter 2803 Wesleyan Drive, Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 6 Depertment of Importent: If It 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 7/17/2004 Baltimore, Md. 22 Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee Buin alle 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed usa as the burial-trens Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) funeral director, page 2 should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eumoni Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? hes 2. NO 1 ☐ Yes 2 ☐ No 1 Tyes this cartificate 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Other: Medical Certification: To 1 Yes 2 No 1 Inpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpetient 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of within 24 hours after deeth.

To the Funeral Director: After it completely filled in by the funeral completely filled in the funeral compl Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E

State Registrar

29a. Certifier

31. Date filed

(Check only one)

29b. Signature end title of certifier

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DHMH 16 Rev 6/95

Schwarze

deeth (Item 23e) (Type, Print)

Regist

1 Fortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29c. License number

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and M 1- Registrer Certificate of Death		2001 0-
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	Funeral Director	iei	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 86 Yrs. Months Days Hours Min. 86 Yrs. Months Days Hours Min.		BALTIMORE
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Interval Batween Onset and Death
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	Amend Item #14 per intormant 6835 971764 Fast and w	Reg. No. 2004 22315
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/Medical	Gertrude Soistman	July 08 2004 6:55 Am
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	
	Future Care College Parkway Arold	Anne Arundel
Funeral Director	5. Social Security Number 20-80-6760 6. Sex 1 Months Prize 1 Months 1 Months Prize 1 Months Priz	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Feb 11, 1917 Maryland
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		e, m) 21108
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	

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			Decedent's Name (First, Middle, La	ist)			_	2. Date of Death		3. Time of Death
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	Funeral			.77	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear)	Birthplace (State or Foreign Country)
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	Mar Marian	ctor	MD Montgom	ery	Silver	Spring				1 ☐ Yes 2X No
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e,	s 1 and of Health item 27 other to		Judy Estey/daugh 20a. Method of Disposition	ter	6UZU 20b. Place of Dispo			thesda, M		
Baltimore, Maryland 21215-0036			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special	y) /	cemetery, cren	natory or other plac	e) 			ity or Town, State
Ball	permit. Page Department of Important: if eny injury or once.		Signature of Funeral Service Lie	Wade, Dire	St Ba	Name and Address ate Anato ltimore,	ss of Facility Omy Board MD 2120	l 655 W. E	Baltimo	re Street
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•			· Carol He	llan N	d	O.C.M	.E.	Ju	ıly 12,	2004
	1		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type F				-	
_			CHROCH. A	TLLAW M	d		on Street	. Baltimo	me. Ma	ryland 21201

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	Physici	ian	1. Decedent's Name (First, Middle, John Sevier	Last)							2. Date of D		004	Year	3. Time 8:00	of Death AM M
	/Medic Examir		4a. Facility Name (If not institution, Manor Care Rus		ber)		4b. City	Town, or	Location of			4c. County of Deeth Baltimore		•==		
	Funeral Director		238-34-0987	.Sex 7 1 🖾 M 2 🗆 F	78 Age (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Nov 23	irth ay, Yea	925	9. Birth Cou Nor	place (State ntry) th Can	orForeign rolina
	ne Maryland 8a-f show	ector		imore	10c. Ci	ty, Town or Lo	on						10d. Inside City Limits 1 ☐ Yes 2X No			
	with the	i Dire	10e. Street and Number 7001 N. Charles	Street			10f. Zij	Code	21204			10g. (g. Citizen of What Country? USA			
USP	d within 72 hours after death with the Maryland jiene. I than "natural", or iteme 23a or 28a-1 show The Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? 2 □ No	unk	Was Dece If Yes, spe 1 Yes		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. Specify: White			
9500-612	ithin 72 ho ne. han "naturi nedical i	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4	4or 5+)	life.	kind of wo	ork done a se retired,	furing mos	t of worki	-		Kind of Bu			
yland 21	be filed stal Hygi d other svent, I	To Be Col	17. Father's Name (First, Middle, La James Creigh		r	Cle	rk ty	pist			(First, Middle Miller				al Sei	vices
Mar			19a. Informant's Name/Relationship Manor Care Ruxto				_				l Route Numb			State, Zip 21204		
saltimore,	permit. Pages 1 and 2 Department of Health Important: if item 27 I any injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☑ Other (Spe		ate	Place of Dispo cemetery, crem	sition (Nai natory or o	ne of other place	e)	D	ate	20c.	Location -	City or To	own, State	
Ball	permit. Departr Importu sny inji		21 Signature of Funeral Service Line Ronal I d S	Wade, Di	roctor	S B	tate altin	Anat nore,	ony E MD	Soard 2120	655 W	• B	altim	ore	Street	Ė
	Physician /Medical Examiner		23a. PArt1. Enter the disease for or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	a. AC	used the deat ch line. . UTE r as a consec	511	er the mod	de of dying	g, such as	cardiac o	r respiratory a	arrest,			Approxima Interval Be Onset and	tween
08/pn,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	r as a conseq											
. Box	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ⊡Feta ntattime of d	uldéath 3□	Ectopic pr						23d. Date Mor	e of delive		Year
ras, r	requires that the een signed by th nould be detache	þ	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the ur	nderlying o	ause give	n in Part I.					ibute to th	ne cause of	death? D nknown
Lec	The lay ate has page 2	Completed									24a. Was auto perfo 1 □ Yes		d p	Vere auto prior to con leath?	psy findings mpletion of a	available cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗓 No	Hospital:	patient 2	ER/Outpatien	t 3 🗆 DO	Othe			(Check only only only only only only only only		6 □Oth4	ar (Specifi	wl	
ion oi	tending Phys Jeath. tor: After this the funeral dir	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of (Month,		28b. Time of Injury		8c. Injury Work	at	2	28d. Describe				·/	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 286. Place o	f Injury - At h , etc. <i>(Specif</i>	ome, farm, stre	eet, factor	y, office		2	28f. Location (City or To	Street a wn, Sta	ind Numbe	er or Rum	l Route Nun	nber,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the b aminer: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred restigation	at the time, in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(date a	s) and mar nd place, a	nner as st and due to	ated. the cause(s	s)
	To t To t	Σ	29b. Signature and title obcepifier	Shiled	ims			D-		49	,		ate signed			
			30. Name and address of person when AH. CHILA	DI.MO.	76		Print)	EK	i	Dr.	Fou	50	N,	40	212	204
	Sta Registr		31. Date filed (Month, Day, Year)	Sanar Sanar	gistrar's Signa		ach.	/								,

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Me 1- State Registrar AMEND ITEM #31 PER DVR G833 This Date Def Death	ental Hygier Reg.		00010
				2. Date of Death	NO. UUL	3. Time of Death
	Physicia		ERVIN White		Day Year	8:0 Yem
-	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	0.0
			BON SECOURS HOSPITAL BALTIMORE		N/A	
	Funeral		Months Days Hours Min	B. Date of Birth (Month, Day, Ye	9. Birthplac	e (State or Foreign
	Director		219 01 7701 1 2 F 91 Yrs. Months Days Hours Mill.	FEB. 2,	1913 MARY	LAND
	land ow		10a. State 10b. County 10c. City, Town or Location		10d	. Inside City Limits
	Mary	tor	MD. N/A BALTIMORE			1 XYes 2 ☐ No
	h the	irec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country	n
	23a c	aiD	2306 ROBB STREET 21218	U	.S. OF A.	
2-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 ie marked other then "naturel", or Items 23a or 28e-f ehow or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 XNo If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Black, White, etc Specify: ACK	
5-0	72 he	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b	. Kind of Business/Indus	stry
2121	within ene. then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+) COOK	E.	OOD SERVI	CE
	filed with Hygiene. other the	င္ပ	8TH UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (CE
an	ld be ental ked o	To Be		WHITE	(DECEASE	D)
Maryland	should be fand Mental I ie marked o'eumatic eve	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)	Route Number, Cit	ty or Town, State, Zip Co	ode)
-	1 and 2 Health a em 27 le		TAMMY M. WHITE (DAUGHTER) 2306 ROBB STREET B	ALTIMOR	E, MARYLAN	D 21218
Baltimore	Pages 1 and of He Int: If Item		20a. Method of Disposition 1 BUNAT AUCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY 7/12		. Location - City or Town	
Baltii	permit. Pages 'Department of H Important: If Ite any injury or of		21. Signature of the all Service Licensee I.E.W.J.S. T. GWYNN 22.E.W.J.S. defines company of the company of t			
			23a, Part1. Error the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or		BALTO.,	pproximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			terval Between nset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a	12E		
М	Examiner		Sequentially list conditions b. Cardiac Arrhythmia			
	₽ #	ner	if any leading to immediate Due to (or as a consequence of):	P	2	
	ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated eyents resulting in death) Last c. Chronic Obstructive Due to (or as a consequence of):	WIMOR	MRY DISER	Be_
60,	be ex ician burial	a E	Due to (or as a consequence or).			
68760,	phys phys s the	edicai	d.			
.O. Box (ne death certii the attending hed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Da	ay Year
Δ.	ires that the signed by I be detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
rds	quires n sigr ald be	d by	Hypertension	1 Yes	2 No 3 Probab	ly 4 ∐Unknown
Records,	aw requir 1s been si 2 should	Completed	PROSTATIC CARCINOMA	24a. Was an	24b. Were autopsy	findings available
Re	The lav	mo		autopsy performed	? death?	letion of cause of
Vital		Φ	25. Was case referred to medical 26. Place of Death (
_f <	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Hesidence	6 ☐ Other (Specify)	
n of	ding Pt		1 Natural 5 Pending (Month, Day Year) Injury Work?	3d. Describe how in	njury occurred	
Sio	Attending It death. ctor: After by the fune	cati	2 Accident investigation M 1 Yes 2 No			
Division	l or At after o Direction by	Certification:	4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, St	and Number or Rural R ate)	oute Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause	e(s) and manner as state and place, and due to th	ed. e cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number	29d. l	Date signed (Month, Da	y, Year)
	n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 0	7/05/20	04
_			DONOVAN PARISES 2000 W. Baltin	noRo	Street, to	x11.2/23
	Sta Registr		31. Date filed (Nonth, Day Year) 32. Registrar's Signature 32. Registrar's Signature 4 Server & Son	ald I		
			1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			

Tarik 04-04 RJ	Walker 585
	Physicia /Medio Examin

	. waтке: :585	-	* -	be or Print in Bla				-		e.
-			1 _ State	tate of Maryland		tificate of			giene Reg. Nø?	20010
			Registrar 1. Decedent's Name (First, Middle, Last)			inoato or i	Boatti	2. Date of Dea	ıth	3. Time of Death
	Physici		TARIK LA	TEEF	WA	LKER		July 13	,	0005 A. M
2	/Medio Examin		4a. Fecility Name (If not institution, give street				r Location of Death		4c. County of	Death
			University Shock Tr	auma		Balti				IA
	Funeral		5. Social Security Number 6. Sex 12/16-84-6561 12/19	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9	Birthplace (State or Foreign Country)
Н	Director		Usual Residence of Decedent	00				NOV. 07	,1975	MARYLAND
	how		10a. State 10b. County	10c. City, T	own or Lo	cation		4		10d. Inside City Limits
	Ba-1-s	ctor	MARYLAND N/	9		BAL	LTIMOR	E CIT	-1/	1 Øves 2 □ No
	death with the Maryland ms 23a or 28a-f show rmst be rotified at	Directo	10e. Street and Number			10f. Zip Code	A . A	7	10g. Citizen of Wha	at Country?
	s 238	eral		WT STREE Was Decedent Ever in U.S.		Vac Decedent of H	d/2/	ecity Ves or No-	14 Bace	SA - American Indian,
^	riter d	Funeral	1 Never Married 2 Married	Armed Force <i>s</i> ? 1	į.		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
2-003p	n 72 hours after death with the Marylan "natural", or liems 23s or 28s-1 show scilical Examinar must be rediffed at	by		If Yes, Give Year or Dates:		Yes 221No	Specify:		Specify:	BLACK
ე ი	72 hc	Completed	15. Decedent's Education (Specify only highest grade co	on 1 mpleted)	6a. Deced	lent's Usual Occup	ation during most of work d)	ing	16b. Kind of Busin	ness/Industry
V	filed within Hygiene. ther than "	mp		College (1-4or 5+)	* 1				12 IN	
N	Hygie Hygie ther I	e Co	12 HIGRADE 17. Father's Name (First, Middle, Last)			JUSER	EEPING 18. Mother's Name		Maiden Sumame)	
yland	ld be ental ked c	To B	WALTER	WAL	KE	R	MARI	1-1/N	SHA	TNNON
Ξ.	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type,				and Number or Run	al Route Numbe		
, Ma	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		MARILYN SHANNON		319	ILCHE	STER AV	E. BAL	TIHORE, M	10,21218
9			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Reme	ceme	etery, cren	sition (Name of natory or other place	ce)		20c. Location - Cit	•
ращтог	permit. Page Department of Important: If any injury or once.		'4 □Donation 5 □Other (Specify)	MT.	210	N CEMETE	RY 07-1	6-04	LANS004	ONE MARYLAND LERAL HOME MD. 21217
n n	Depariment Department		21. Signal re of Fu anal Fervice Licens to	1101	22	Name and Addre	ss of Facility	ROWN	JR. FUN	ERAL HOME
			23a. Part1. Enter the disease, or complicati	ons that caused the death. I	o not ent	er the mode of dvin	J-ULTO	or respiratory ar	SALTO. P	Approximate
	Discount to the		shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.			•			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Que to (or as a consequen	Ce of):	of Nec	Kandc	nest		-
	Examiner			G(,-					
Ļ,	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):					
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to force a consequent						
ρΩ,	be ex ician burial	al E		Due to (or as a consequen-	00 01).					
280	physic sthe	edica	d							
ROX	death certificate e attending phys id for use as the	Z/M		If yes, outcome of pregnancy					23d. Date o	f delivery
ň	death e atte	icla	in the past 12 months?	1 Live birth 2 Fetal de: 4 Pregnant at time of death		Ectopic pregnancy Other <i>(specify)</i>	′		Month	Day Year
J O	The law requires that the the has been signed by the has been signed by the hage 2 should be detache	Physiclan/M	9 Unknown	9□ Unknown				-	1	
s,	es thai	by	Part II. Other significant conditions contrib	uting to death but not resultin	g in the u	nderlying cau <i>s</i> e giv	en in Part I.			ite to the cause of death?
cora	requir	Completed						1 □ Y	es 22 No 3[□ Probably 4 □Unknown
fec	G (2) (3)	nple						24a. Was a autop:	sy prio	re autopsy findings available r to completion of cause of
<u>I</u>								1 Yes	2 □ No 1	Yes 2□ No
<u> </u>	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 X Yes 2 No	ital: 1 ☐ Inpatient 2 🔀 ER/	Outpatien	t 3 DOA Oth	er: A Dayston He			(C
0	g Phy er this eral d	<u> </u>	27. Manner of Death	8a. Date of Injury 28	b. Time of	28c. Injur			ence 6 Other (Specify)
DIVISION	ath. rr: Aft	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	1:39	PM 10	Yes 2 No	Jub,	ect sh	OT
<u> </u>	r Atte	tific	3 Suicide 6 Could not be determined	8e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (S City or Joy	treet and Nymber of	r Rural Route Number,
2	urs aft ral Di lled ir		/\	CO	ade	my		Ball	TIMORE	. MO
	Hosp 24 hou Fune tely fil	edical	29a. Certifier 1 ☐ Certifying Physicia (Check only 2 ☑ Medical Examiner:	an: To the best of my knowler On the basis of examination	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occuri	and due to the c ed at the time, c	au <i>s</i> e(s) and manne late and place, and	er as stated. due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed (A	fonth, Day, Year)
	₩ S H Ö		Hote Dim	11-400	fr.	0.	C.M.E.		July 13,	2004
	X		30 Name and address of person who comp	leted cause of death (Item 23	a) (Type.	Print)	- Ot 1	D-3/:		13 01001
			PARICIA Aronic		-	111 Pen	n Street,	Baltim	ore, Mary	yland 21201
	Ste	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature						

State Registrar

DHMH 17 Rev 1/2001

JUL 1 6 2004

			For State		partment of Health and Me ertificate of Death	, ,	0001	
			Registrar 1. Decedent's Name (First, Middle, La			Reg. 2. Date of Death	No.	2 2 3 5 0
	Physici		GAREV	h/ h	VILSON		Day 2004 Year	7:15 P M
	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Death		4c. County of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			11 W. 20th ST		BALTIMORE CIT	Y	NI	7
	Funeral		5. Social Security Number 6. S	MY ADE	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	SZ Yrs.		AUG. 20,1	1951 MA	RYLAND
	laryland show		10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	the Mar 28e-f st potified	ctor	MARYLAND N	IA	BALTIMOR 101. Zip Code	5 CITI	/	1 XYes 2 □ No
	or 28	Director	10e. Street and Number	ath of the	10f. Zip Code	10g/	Citizen of What Coun	itry?
	death with the Maryland ms 23a or 28e-f show fmust be notified at	ie	11 WEST X	STREET, APTSI	e 2121	8	USA	? ,
	after dea or items miner m	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
21215-0036	hours after turel', or ite	by	· 3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 Z No Specify:		Specify: RI	on W
200	72 hours "naturel",	Completed	15. Decedent's Ed (Specify only highest gra	ducation 16a. Dece	edent's Usual Occupation	16b	. Kind of Business/Ind	dustry
2	within and the series of the s	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	9	11.	
	iled w lygier her th		17. Father's Name (First, Middle, Last,) IS ABLED	(First Adiabate 14 i	NIA	
Maryland	s should be filed within and Mental Hygiene. Is marked other than sumatic event, ILB M.	o Be	WENDELL	Bows	18. Mother's Name	rirst, Middle, Maid	/.1 . / <	
Z	shoul nd Me mark imati	ř	19a. Informant's Name/Relationship (ing Address (Street and Number or Rural	Route Number, Cit	v or Town, State, Zio	Code)
			STANLEY & WAUNES	BOWSER(BROTHERS) 213	3 N. MONROE Sosition (Name of Da	T. BAL	TO, MD. 2	1223
ore,			20a. Method of Disposition	20b. Place of Disposemetery, cre	osition (Name of Damatory or other place)	te 20c.	Location - City or To	wn, State
<u>Ĕ</u>	Pag ent nt: i		1 Burial 2 □ Cremation 3 □ '4 □ Donation 6 □ Other (Specif	y) MT. CA	+LVARIJ CEME 07-2	1-04 3	ALTIHORE	1110
Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Fun-ral Service Cour	2	2. Name and dress of Facility B	ROWN	R. FUNER	AL HOME
ш	20 E 9 9			NOW ?	2745 N. FULTO,		BALTO. A	1021217
			shock, or heart failure. List only	plications that caused the death. Do not en one cause on each line.	iter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		riosclerotic Cardio	vascular	Disease	
	Examiner			Due to (or as a consequence of):				
		Jer	Sequentially list conditions, and the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):				
	ate be executed obysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	C				
0,	e exe		resulting in death) Last	Due to (or as a consequence of):				
68760	lificate be execu g physicien and as the burial-tran	edicai		. d				
	ding p		IF FEMALE:	23c. If yes, outcome of pregnancy				
Вох	The law requires that the death centif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
P.O.	t the c by the ached	hysi	9 Unknown	9□ Unknown				
	w requires that been signed t should be det	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ord	equire en si	ted				1 Tes	2 No 3 Proba	abiy 4 🖫 Únknown
Records,	lawr las be	Completed				24a. Was an autopsy	24b. Were autop	sy findings available
E B		Con				performed? 1 ☐ Yes 2 🔀	death?	
Vital	ysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death /			
of	Phys this al dii	- To	1 XYes 2 No 27. Manner of Death	1 Inpatient 2 ER/Outpaties		5 Residence	6 NOther (Specify	SCENE
O	rding th. : Afte s fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	of 28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	u. 50501100 1104 111	ary occurred	
Division of	Atter or dea ector by the	ifice	3 Suicide 6 Could not be determined	289. Place of injury - At home, farm, st	reet, factory, office 28	f. Location (Street	and Number or Rural	Route Number,
	tel or s afte el Dir ed in	Certification:	4 [] Nomicide	building, etc. (Specify)		City or Town, Sta	ite)	
	lospii hour uner		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, deat niner: On the basis of examination and/or in	th occurred at the time, date and place, an	d due to the cause	(s) and manner as sta	ited.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	0.16)	and manner stated.				
	To Too	mic.	29b. Signature and title of certifier		29c. License number OCME		Date signed (Month, E ULY 16, 20	
7	\wedge		30 Name and address of the	completed cause of death (Item 23a) (Type,			OLI 10, 20	, U T
	3		Tasha I Giron	D D I/O M.D.	111 Penn Street,	Baltimo	re, Maryla	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Signature	1 .			
	Registr	ar	JUL 1 6 2004	Denva B	spach			

JOMACK, DORETHA

			1 - For State Registrar			Department of F Certificate of	lealth and M	lental Hy	•	J,	22250
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, L FRANKLIN 4a. Fecility Name (If not institution, gi	D.			HAAR r Location of Death	2. Date of De.	ath Day	Year 2004	3. Time of Death 3:04 PM
	Funeral Director		UNIVERSITY OF MARYLES. Social Security Number 6. 219-30-0696 Usual Residence of Decedent		(In yrs. last bit	2 BALTIMO	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da March 1	th y, Ye <i>ar</i>)	N/A	ace (State or Foreign ry) MD
	ith the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Queen A 10e. Street and Number		10c. City, Tow		ensville		10g. Citizen of Wi	hat Count	od. Inside City Limits 1 Yes 2 XNo
036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23e or 28e-f show ent, the Medical Evaniner must be natified a	Funeral	203 Alleghany 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1		13. Was Decedent of H If Yes, specify Cube		ecity Yes or No- Rican, etc.)	- 14. Race	SA - America , White, e	tc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hor Health and Mental Hygiene. Item 27 Is marked other than "naturi other traumatic event, the Medical	Be Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12	rade completed) College (1-4or 5+	-) 16a	Decedent's Usual Decup (Give kind of work done life. DO NOT use retired Engieer Tec		ing	16b. Kind of Bus		,
aryland	should be fill nd Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Las Charles J. 19a. Informant's Name/Relationship	Weishaar	19b	o. Mailing Address (Street	18. Mother's Name Elizabe	eth	F. Zie	emer	Code)
	permit. Pages 1 and 2 should be filed within Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, tra Magnee.		Kimberly Dempsey 20a. Method of Disposition 1 □ Burial 2 🏿 Cremation 3 [Removal from State	20b. Place of cemeter	16 Pennick Di t Disposition (Name of ry, crematory or other place	rive, Ste	vensvil	le, MD 2	1666 ty or Tow	n, State
Baltimore,	permit. Pa Departmer Important any injury once.		1 Donation 5 Other (Special Signature of Funeral Service Lice	-)	Crematory In 22. Name and Address 3111 Mounta	ss of Facility	Stalling	Baltimore gs Funera na. MD 2	al Ho	
	Enysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		ve Hea	not enter the mode of dyin	g, such as cardiac o	r respiratory ar	rest,	í	Approximate interval Between Onset and Death
760,	ate be executed mysician and hysician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.							
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Completed by Physiclan/Med	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	☐Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date Month		r Year
Δ.	w requires that been signed b should be deta	ted by Pl	Part II. Other significant conditions Colon Cancer, M						bacco use contrib es 2 □ No 3	_	
Vital Records,				lmonary etf	ision				med? dea 2 No 1	ere autops or to comp ath? Yes 2	y findings available oletion of cause of
Division of Vit	ng Phys fter this ineral dir	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Matural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) II	Time of 28c. Injury Work	at 2	ne 5 ☐ Reside	ne) ence 6 ⊡Other ow injury occurred		
Divi	pital or ours afte eral Dir filled in	al Certifi	4 Homicide determined	building, etc.	(Specify)	rm, street, factory, office	e date and place a	nd due to the c	Questa) and mann		
	To the Hos within 24 hd To the Fun completely	Medical	(Check only 2 ☐ Medical Example) 29b. Signature and title of certifier	miner: On the basis of e and manner state	xamination and	d/or investigation, in my op	number	d at the time, d	ate and place, and 19d. Date signed (I	d due to the	ne cause(s)
	15		30. Name and address of person who 22 South GREE 31. Date filed (Month, Day, Year)	ENE ST. B	ALTIMO					-,	
	Sta Registr		JUL 1 6 2004	2. Registrar	s signature	book					

CPM 04-04606 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Wynegar State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Item#23a,27,28a-f,Per ME,G834/18/1274/04 LTBath Reg. No. U 1 L Unpend 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Michael Keith Wynegar July 2004 20:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A6601 Birchwood Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 46 Yrs. **Director** 021-46-3091 May 20. Maine Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumatic evant, the Medical Evanding must be notified at 1 XYes 2 No Directo Maryland N/A Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23e 6601 Birchwood Avenue 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ð 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Delaware-MD Chapter permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene, important: if itam 27 is marked other than eny injury or other traumatic. College (1-4or 5+) Elementary/Secondary (0-12) Executive Board Director Paralyzed Veterans 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Clyde Wynegar, Jr. Roberta H. Burgess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6601 Birchwood Avenue, Baltimore, MD 21214 Mrs. Ruth Ann Wynegar (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 17/16/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes elen Buin a We 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Methadone Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1X Yes 1 Yes 2 No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1

Yes 2□ No 2 Poured Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: **Tourid** 5 Pending investigation 6 Could not be 1 Natural 7:50 p M Unknown death. 7-13-04 1 ☐ Yes 2 No s after death 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, 6601 To Bistrathwood Avenue Baltimore, Maryland 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Time Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cemiliar

To the Hospital or Attending within 24 hours a To the Funerel I

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of Math (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

berg

MD

1 6 2004

ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 14, 2004

CPM 04-03807 JESSE WHITTINGTON

			For State Registrar		State of Ma	•	partment of F e <i>rtificate of</i>		and Mental H	ygiene Reg. No	2001	22354
	Physici	'n	1. Decedent's Name (F	First, Middle, Las	")	,			2. Date of _Month		7, 2004	3. Time of Death
-	/Medic	al		Whitting			1) O': T		June			22:30 M
	Examin	er	4a. Facility Name (If no 1720 Nort				4b. City, Town, o	imore		40	. County of Death	
	Funeral		5. Social Security Num			e (In yrs. last birthda	y) If Under 1 Year	If Under	24 Hrs. 8. Date of	Birth	9. Birth	place (State or Foreign ntry) unk
	Director			1]	M 2□F	58 Yrs.	Months Days	Hours	Min. June	4, Year)	945	ntry) unk
	pur *		Usual Residence of De	ecedent 0b. County		10c. City, Town or	Location					10d. Inside City Limits
	Aaryla shov	J.	MD	ob. Oddiny			timore					1X Yes 2 No
	28e-	rect	10e. Street and Number	er			10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
	n with	Funeral Director	1720 N. B	Broadway			21	213			USA	
	death	ner	11. Marital Status	unk	12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of F If Yes, specify Cub	lispanic Orig	gin? (Specify Yes or . Puerto Rican, etc.)	No-	14. Race - Ameri Black, White,	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show Iteal Examinat must be notified at	þ	1 ☐ Never Married 3 ☐ Widowed 4 [1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No					lack
5-0	72 ho	Completed		5. Decedent's Ed only highest gra		(G	cedent's Usual Occup ive kind of work done	during most	unk t of working	16b. K	and of Business/Ir	dustry unk
121	within ene. than	mpi	Elementary/Second		College (1-4or	5+) life	a. DO NOT use retire	d)				
, D	filed v Hygie ther t	ပ္ပ	unk 17. Father's Name (Fit		ınk		unk	18. Mothe	r's Name (First, Midd	ile, Maiden	Sumame)	unk
an	ld be ental ked o	To Be										
Maryland	1 and 2 should be filled within Health and Mental Hygiene. em 27 is marked other than ' ither treumatic avent, II e M.	-	19a. Informant's Nam	e/Relationship (7	ype, Print)	19b. M	ailing Address (Street	and Numbe	or or Rural Route Nur	nber, City	or Town, State, Zij	Code)
Σ	and 2 salth a n 27 is er tre		O.C.M.E.				l Penn Sti	reet B		-	21201	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Items 23a or 28e-f show any injury or other treumatic avent, the Marical Examinar must be notified at once.		20a. Method of Dispose 1 Burial 2 0 4 Donation 5	Cremation 3	Removal from State	cemetery, o	sposition (Name of crematory or other pla	ce)	Date	20c. L	ocation - City or T	own, State
Balti	permit. Departri Importa any inju		21. Signalure of Eune			eutor	22. Name and Addre State Anat Baltimore,	omy B	y oard 655 V 21201	V. Ba	ltimore S	Street
	EUI		23a. Part . Enter the shock, or heart f	disease, or comp	olications that caused				cardiac or respirator	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Findisease or condition				cardiovas					Onset and Death
	/Medical		resulting in death)		a.	a consequence of):						
н	Examiner	_	Sequentially list condi	itions,	b							
	ed sit	nine	if any, leading to immo cause. Enter Orderly Cause (Disease or in)	ediate	Due to (or as	a consequence of):						
	xecut and al-trar	Examiner	that initiated events resulting in death) Las		c Due to (or as	a consequence of):						
68760,	ficate be executed g physician and is the burial-transit	edicai E			d							
	T (7) (7)											
Вох	death certif e attending id for use as	an/l	1F FEMALE: 23b. Was decedent p in the past 12 me			2 Fetal death	3 □Ectopic pregnanc	y			23d. Date of deliv	ery Day Year
	0 0	Physician/M	1 Yes 2 1		4☐ Pregnant a 9☐ Unknown	t time of death	5 Other (specify)			-	NOTE:	Suy . ou.
P.0	requires that the de een signed by the a nould be detached t		Part II. Other significa	ant conditions o	ontributing to death b	eut not resulting in th	e underlying cause gr	ven in Part I.	23e. D	d tobacco	use contribute to t	he cause of death?
Division of Vital Records,	uires sign id be	d by				_			11	☐ Yes 2	□No 3□Pro	bably 4 Unknown
00	> 9 70	Completed							24a. W		24b. Were auto	opsy findings available ompletion of cause of
Re	a <u>- a</u>	ошь							_/ pe	itopsy orformed? s 2 ☐ No	death?	ompletion of cause of 2□ No
ita		a	25. Was case referred	d to medical				26. Place	of Death (Check on			
f V	Physic this ce al direc	To B	examiner? 1 X Yes 2 ☐ No	0	Hospital:	ent 2 ER/Outpa	tient 3 DOA	her: 4 🗆 Nu	rsing Home 5 🗆 R		6X Other (Speci	(ty) SCENE
0	fter fter iner	ou:	27. Manner of Death 1 XNatural	5 Pending	28a. Date of Inju (Month, Da	ıry 28b. Tim ıy Year) Inju	y Wo	rk?	28d. Descrit	e how inju	ry occurred	
Sio	death. ctor: A y the fu	icati	2 Accident	investigation		iun. At homo, form	M 1 Street, factory, office]Yes 2□		(Street at	nd Number or Rur	al Route Number
Div	al or Attends after death	Certification;	4 Homicide	determined	building, e	c. (Specify)	street, factory, office		City or	Town, State	9)	
	To the Hospital or Attuvithin 24 hours after de To the Funeral Directo completely filled in by the	edical (29a. Certifier 1 (Check only 2- one)	Certifying Ph Medical Exan	ysician: To the best niner: On the basis of and manner st	f examination and/o	eath occurred at the ti r investigation, in my	ime, date an opinion, dea	d place, and due to t th occurred at the tim	he cause(s ie, date an) and manner as s d place, and due t	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and tit	le of certifier	1	11	29c. Licen:				ite signed (Month,	
			•		WIL	11		0.C	.M.E.	Jı	une 08, 1	2004
			30. Name and addres	KM, 1	completed cause of		pe, Print) 1 Penn Str	reet,	Baltimore	, Mar	yland 21	201
	Sta Regist	• 44	31. Date filed (Month,		82. Regist	rar's Signatur	Spals					

			_ FOr	of Maryland / [Department of Healt		giene
			1 - State Registrar		Certificate of Dea		Reg. No 2 1 1 2 2 2 5 5
	Physici	an	Decedent's Name (First, Middle, Last) Nadine S. Yount			2. Date of Dea	Day, Year, Full
7-	/Medic		4a. Facility Name (If not institution, give street and i		4b City, Town, or Locati	tion of Death	4c. County of Death
	Examin	er	Franklin Sanar	= HOSPIT	N ROSPHO	2/9	Ba) timose
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	Months Days Hou	nder 24 Hrs. 8. Date of Birt urs Min. (Month, Da	v. Year) Country)
	Director		216-30-6217 1□M 2\\ \[\text{T} \]	69	Yrs.	Sept.	13,1934 WestVirgini
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	Mary I ah	tor	MD Baltimore		Essex		1 □Yes 2ĀNo
	th the	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	23a c	rai	5 Brett Court		2122		USA
	er de	nue	Armed	ocedent Ever in U.S. Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f ahow the Modical Examiran must be mullind an	by F	1 Never Married 2 Married 1 Ye. 3 Widowed 4 Divorced Year of		1 ☐ Yes 2 🖾 No Spec	ecify:	SpecifyWhite
21215-0036	72 hou	Completed	15. Decedent's Education		Decedent's Usual Occupation (Give kind of work done during i	most of working	16b. Kind of Business/Industry
21	ithin 7 18. 18. "r	npie	(Specify only highest grade complete Elementary/Secondary (0-12) College	(1-4or 5+)	life. DO NOT use retired)	most or working	n3
121	led w lygier her th		12th 17. Father's Name (First, Middle, Last)		Cook	Aother's Name (First, Middle,	Food Maiden Sumama)
anc	d be fantal he ed ot	Be C	Orville G. Currey			lanche E. L	·
Maryland	iges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, its Medical	မှ	19a. Informant's Name/Relationship (Type, Print)	196			er, City or Town, State, Zip Code)
	1 and 2 Health a tem 27 is		Stephen Younts / s	on 1	5 Colgate Cou	urt Catonsv	ille MD 21228
ore,	es 1 a of He fiterr		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal fro	m State cemete	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or Town, State
Ĕ	Ly It de Pa		`4 □ Donation 5 □ Other (Specify)	Bayv	iew Crematory		Baltimore MD
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr QRG9.		21. Signature of Funeral Service Licensee	mare Mu	22. Name and Address of Fa	^{Facility} ConnellyH Ave. Baltir	FuneralHomeofEssex more MD 21221
	TEN!		23a. Part1. Enter the disease, or competitions that shock, or heart failure. List and the cause of	t caused the death. D	nter the mode of dying, such		rrest, Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	sumonio			Onset and Death
1	/Medical Examiner		resulting in death)	o (or as a consequence	of):		
		ē	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence	of):		
	uted d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events c.				
o,	e exectan an an urial-tr	Exa	resulting in death) Last Due	o (or as a consequence	of):		
8760,	icate be executed physician and s the burial-transit	dicai	d				
9	ding p	/Mec	IF FEMALE: 23c If yes	outcome of pregnancy			23d. Data of delivery
Вох	atten for us	Physician/Me	in the past 12 months?	e birth 2 Fetal death	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	t the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Un	known			
	The law requires that the death certificate has been signed by the attending progge 2 should be detached for use as	by P	Part II. Other significant conditions contributing to	death but not resulting i	in the underlying cause given in P		obacco use contribute to the cause of death?
Records,	w require been si should l	ted				10)	Yes 3 No 3 Probably 4 Unknown
ec	alaw ras bu	Completed				24a. Was autop	
E E	ician: The lav certificate has rector, page 2					YES Yes	2 No 1 Yes 2 No
Vital	Phyaician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/O	Other	Place of Death <i>(Check only o</i> ☐ Nursing Home 5 ☐ Resid	
of	g Phys er this eral di	-	27. Manner of Death 28a. Da	te of Injury 28b.	Time of 28c. Injury at 19 Work?		now injury occurred
ion	anding Fath. or: After	atio	2 Accident investigation	onin, Day Year)	M 1 Yes 2	2 🗆 No	
Division	i or Atte after de Directe in by ti	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ice of Injury - At home, fa ilding, etc. (Specify)	arm, street, factory, office	28f. Location (5 City or Tox	Street and Number or Rural Route Number, vn, State)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	(Check only 2 Medical Examiner: On the	the best of my knowledge basis of examination are anner stated.	e, death occurred at the time, datend/or investigation, in my opinion,	te and place, and due to the	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of ceptifier		29c. License numb	ber	29d. Date signed (Month, Day, Year)
	, , , , - 0		1 (Cm	Zm	05473	36	7/14/04
	3		30. Name and a cross of person who complyed on Round Auveung	ause of deal (tem 23a)	(Type, Print) NKIN Squal	e Orive Ba	Himore MD 21237
	Sta Regist		N 1 1 1 0 7 7 - V 1 1	Registrar's Signature	South	, , , , , , , , , , , , , , , , , , ,	

			For Stete Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F			iene	4 22356
	Physici /Medic		1. Decedent's Name (First, Middle,	P Vac	ahe 11	III		2. Date of Death Month	Day	Year 3:17 PM
X	Examin	er	4a. Facility Name (If not institution, Bultimore VA)	UC Exten	Led Care e (In yrs. last birthday)	4b. City, Town, o Balton If Under 1 Year	r Location of Death	O. Date of Birth		Baltimore City
	Funeral Director		5. Social Security Number 221.16.1291 Usual Residence of Decedent	3. Sex 121 M 2□ F	75 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, August 22		Birthplace (State or Foreign Country) Delaware
	Marylano a-f show	tor	10a. State 10b. County Maryland	Cecil	10c. City, Town or Lo		Rising Sun			10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23e or 28	Funeral Director	10e. Street and Number 1223 Ridge Road			10f. Zip Code	21911	10	og. Citizen of W	hat Country? U.S.A.
-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or items 23e or 28a-f show other traumatic event, the Modical Examinational be notified at	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	- 1959	Was Decedent of H If Yes, specify Cubi 1 Yes 2 No dent's Usual Occup	dispanic Origin? (Spean, Mexican, Puerto Specify: pation			- American Indian, x, White, etc. White
21215-0036	filed within 72 Hygiene. other then "ne ent, I've Modic	Completed	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retired	during most of worki	ng		Electronics
Maryland	should be filed ind Mental Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, L Lewi	_{ast)} s P. Yacabell			18. Mother's Name		ary Delapo	•
	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationsh Ms. Barbara Yaca		se	1223 Ridge R	and Number or Rura Road Rising Su	ın, Maryland	21911	
Baltimore,	Page nent c ant: If ury or		20a. Method of Disposition 1 ★ Berial 2 ☐ Cremation 2 ☐ Donation 5 ☐ Other (Sp	ecity)	Delaware	matory`or other place • Veterans Me	^{சை)} emorial 07/	14/2004	W	City or Town, State
Balt	permit. Pag Department Importent: I any injury o once.		23. Sign for of funeral Service L ALLINGTON 23a Part 1. Enter the disease or of shock, or heart failurg. List of	Uch M	, ,		ess of Facility n-Griffith Fund Kirkwood High	vay viniting	91011, DE	9805
8760,	Physician /Medical Examiner bullians and physician and the prijal-transit the prijal-transit physician and physici	dical Examiner	Infmediate Cause (Final disease or condition desulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of): a consequence of):		Squam	ous C	e 11 (g)	ncer 4 mont
.O. Box 6	The law requires that the death centificate be executed tile has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	у		23d. Date Mon	ol delivery th Day Year
ecords, P	quires that in signed b uld be deta	by	Part II. Other significant condition	ns contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.			bute to the cause of death? 3 Probably 4 Dunknown
α		Completed						24a. Was an autopsy perform	red?	ere autopsy findings available nor to completion of cause of eath? Yes 2
Vital	Phyeicien: The this certificate ral director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ② →	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3□ DOA Oth	26. Place of Death	(Check only one		(Specify)
Division of	ding h. After fune	Certification: 7	27. Manner Death 1 Natural 5 Pending investig: 2 Accident 6 Could n 4 Homicide	ot be 28e. Place of Inj	ry Year) 28b. Time of Injury ury - At home, larm, sto. (Specify)	M 1	ry at rk? Yes 2 □ No	28d. Describe ho	w injury occurre	
Ö	spital or A hours after inerel Direct y filled in by		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge, deat	h occurred at the tir	me, date and place, a	and due to the ca	use(s) and man	ner as stated.
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medicel E one) 29b. Signature and title of certifier	xaminer: On the basis of and manner sta	I examination and/or in		se number			(Month, Day, Year)
•	10		30. Name and address of person v	no complete cause of d	eath (Item 23a) (Type,		5/0/	0 0	Uly 7	2004
	Sta	ate	31. Date filed (Month, Day, Year)		M.D. Ba ar's Signature	Itimore	WAMC	Effer	nucd	Care
	Regist	rar	JUL 1 6 20	104 Same	us by	Son V				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					State	OT IVI	aryıan	•			leaith and Death	Mental Hy	ygiene Reg. No.?	104/	222	57		
.5	Physicia	n		ecedent's Name (First, Middle, Last)							2. Dete of D Month	Dey	Year	3: Time of D	èath /			
4	/Medica	al .	Inez					nderso	n		th City Town or	June 1			9:15	PM		
-	Examine	r #	4e Fecility Name (If			n <i>umber)</i>				•	4b. City, Town, or			nty of Deeth				
-	Funeral		Crescent (5. Social Security Nu	6. Sex				er 1 Year	Riverdale Prince George If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace Country) Feb. 26, 1916 Georgia				orge spiece (State or i untry)	Foreign				
ı	Director		253-20-369		1 □ M 2 X □ F		88	Yrs.	Months	Days	Hours Min	Feb. 26	1916 19 16	Geor	intry) cgia			
	and		Usuel Residence of I 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	ocation						10d. Inside City	Limits		
	th with the Marylar 23a or 28e-f show ust be notified at	ខ្ន	Maryland I	Prince	George		Riv	erda1e							¶∑ Yes 2	2 🗆 No		
	r 28e	2	10e. Street and Num		ocorge		ICIV	CIGGIE		ip Code			10g. Citizen o	f Whet Cou	intry?			
	th with	a D	4409 East	West H	Highway					207	37		U.S.A	١.				
020	or items	3	11. Marital Status 1 Never Marrie 3 Widowed 4		ed 1 ☐ Ye If Yes,	Forces? s 2X Give Dates:				edent of H ecify Cuba 200 No	lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or N rto Rican, etc.)	14. R B	lack, White				
21215-0020	c • a ·	Completed by	(Specif	's Education t grede complete College	completed) (G College (1-4or 5+)		(Give	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)			orking	16b. Kind of Business/Industry		ndustry				
2	e filed within I Hygiene. other than	ខ្ទ	17. Father's Name (F	acti			CI	erk		18 Mother's Na	Privat Ame (First, Middle, Maiden Sumame)			е				
Maryland	Mental I Mental I arked or	200	Hue Hines	mat, madre, t	2431)						Adell :		B, Marden Sunn	11116)				
ary	2 should be and Menta is marked aumetic e	=	19a. Informant's Nar	ne/Relationsh	nip (Type, Print)			19b. Maili	ng Addre	ss (Street	and Number or Fi		ber, City or Tow	n, Stete, Zi	ip Code)			
	1 and 2 s Health ar am 27 is other trau	1	Theodore A	Anderso	n/Husba	nd		2004	Fran	klin	St., NE	Washing	gton, D.	.C. 20	018			
Baltimore,	oemit. Pages 1 and Department of Health mportant: If Itam 27 any Injury or other to ance.	1	20a. Mathod of Dispo 1 ☐ Burial 2 ☐ 4 ☐ Donation 5	Cremation		m State			Nati	ona1	Cemetery			iang1	le, Virg	ginia		
Balt	permit. Pag Department Important: If any Injury o		21. Signature of Fun	ral Service L	icensee WM			34	Name a	and Addres	ss of Facility For Isburg Ro	rt Linco	oln Fune	ral F	Home			
		+	23a. Pert1. Enter the shock, or heart	disease, or of failure. List of	complications tha	t caused	the deat							110 20	Approximate Interval Between	een		
7	Physician /Medical		Immediate Cause (F disease or condition	inal							ascular i				Onset and De	eath		
	Examiner	20	Due to (or es a consequence of):															
,09	tificete be executed g physician and es the buriel-transit	clan/Med	Sequentially list conc if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	ditions, nediate ying njury	b	Due to (or as a consequence of).												
Box 68760,	= O 0		resulting in death) La	ist	d	Due to (or as a consequence of):									Ų			
	death		Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause of						cause give	en in Part I.	I tobacco uee o	ontribute	to the cause of	death?				
s, P.O	ires thet the death cersigned by the attending do be detached for use		Dementia							1	Yes 2⊠ No	3 □ Pro	obabły 4⊡Ur	nknown				
Records,	The law requires that the death certained has been signed by the attending page 2 should be detached for use	Completed by	pleted b	pieted b	firm .								-15		s an autopsy ormed?	a\ cc	Vere autopsy find vailable prior to ompletion of cau f death?	
E R		5										10	Yes 2⊠No	1	□Yes 2□N	io		
Vita	ysician: The scarificate director, par		25. Wes case referre examiner?	d to medical	I de en itel					150		ath (Check only	h (Check only one)					
of Vital	hya his		1 ☐ Yes 2 ♣ N 27. Manner of Death							Home 5 Res			fy)					
	te la la		13☑ Naturel 2 ☐ Accident	5 Pending	(Mc	onth, De	Year)	28b. Time of Injury	м	28c. Injun Worl	Yes 2 □ No	28d. Describe	28d. Describe how injury occurred					
Division	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral Maculani Ceretiff celes.	מוווימ	3 Suicide 4 Homicide	ot be 28e. Pla						281. Location City or To	281. Location (Street and Number or Rural Route Number, City or Town, Stete)			Эґ,				
	the Hospital or thin 24 hours aft. The Funeral Direction of the Funeral Direction of the Funeral Carlon of the funeral Carlon of the		29a. Certifier (Check only one)	☐ Certilying ☐ Medical E	Physician: To the xaminer: On the and ma	basis of	examinat	wladge death tion and/or in	oncurra	at the tin n, in my o	e data and place pinion, death occi	e, and due to the urred at the time	cause(s) and r , date and place	and due t	itsled to the cause(s)	1		
	Withir To the comp		29b. Signature and tit	tle of certifier	0 0		101	La	0 25	C. License	number	2	29d. Date sign		,			
2	(10)	1	30. Name end addres											r r v Stir	2004			
Ē.	State		Paul A.	, Day, Year)	32.	Registra	ar's Signa	nsbury ture		а Ну	attsvil]	ie, Mary	Tand 20	/81))		
	 Registrar 		JUN	2 9 200	14	De.	N.	Loon										

DHMH 16 Rev 6/95

			1 - State AMEND ITEM				urtment of F		Mental Hy	ygiene Reg. (yò.)	11. 2	2250
	Dhusia		1. Decedent's Name (First, Middle,	Last)					2. Date of D Month		Year	3. Time of Death
	Physic /Medi		DOROTHY	ELIZABETH	AZ	OTO			May	\ 29 a		1211 M
	Exami	ner	4a. Facility Name (If not institution,			100		r Location of Dea	th	4c. Coun	Wood Death	4143
			16111134111 1/0/	· mica	e (In yrs. la		If Under 1 Year	1/364/1/ If Under 24 Hr	S 0 Date of B	i alla		
	Funeral Director		085-05-3408 Usual Residence of Decedent	1 M 2 X F	85	Yrs.	Months Days	Hours Min		6,1919	Counti	ace (State or Foreign ry) necticut
	death with the Maryland ms 23a or 28e-f show		10a. State 10b. County		10c. City,	Town or Lo	cation				10	d. Inside City Limits
	Man B-1 sh	tor	Marvland Wico	nico	Pa	rsonsb	ura					1 X Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Countr	ry?
	23a		8040 Holt Road	d b			2184	9		USA		
	er deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	2		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (i an, Mexican, Pue	Specify Yes or N rto Rican, etc.)		ice - America ack, White, et	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. This profess: if item 27 is marked other then "naturel; or items 23a or 28e-1 show importent: if item 27 is marked other then "naturel; or items 23a or 28e-1 show any injury or other treumetic event, the Modical Experiment intelligible and once.	by F	1 Never Married Marrie 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No	1	☐ Yes 2½ No	Specify:		Spec		hite
oto 21215-0036	2 hou ature		15. Decedent's	Education		16a. Deced	ent's Usual Occup	ation		16b. Kind of I	Business/Indu	ıstrv
6 2	hin 7:	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+1	(Give l life. [kind of work done of NOT use retired	during most of wo	orking			,
50	ed with	Con	12	_	.,	Но	usewife			Domes	stic	
2/ 2	tal Hy	Be	17. Father's Name (First, Middle, La					18. Mother's Na	me (First, Middle		m <i>e)</i>	
	ould Men Marke Marke	2	Christopher Jo					Lena	Hensh			
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then "treumetic event, the Mental Hygiene.		19a. Informant's Name/Relationship				g Address (Street					Code)
	1 and Health em 27 ther tr		Matthew Azoto/s	oouse	20b. Pla		O Holt R	d., Pars	Date	, MD 218 20c. Location		m State
5	Pages nent of int: If it		1 ☐ Burial 2 🛣 Cremation 3		cei	metery, crem	atory or other place Cremato		31/04		sbury,	
Dent	permit. Pages 1 and Department of Heaith Importent: If item 27 eny injury or other tr		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		Dua							
	permit. Departr Importe eny inju				FSP	20.0	Holloway 501 Snow	Funeral	Home P	rofessio	onal As	sociation
	15-718		23a. Part1. Enter the disease, or co shock, or heart failure. List or	1							1	Approximate
	Physician		Immediate Cause (Final disease or condition	ny one cause on each ii	4		espica	1	Fa lo	~/	, d	nterval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a conseque	ence of):	2301	'' /	1011	٩.		
- 1	Examiner		Sequentially list conditions.	b	m	J		_				
-	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence o):		1.				
	ecut and trar	хап	that initiated events resulting in death) Last	c. Due to (or as	200seque	ance of):	yeo	10011	,			
8760	be e sician buria			A	nto	-> 5	lera	hic Co	ndio.	lascalo	MA.	
687	ificate p phy: as the	edical		a.	612		,				91	
	eath certific attending p	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	ate of delivery	,
P.O. Box	ne death the atte	lcla	in the past 12 months? 1 🗆 Yes 2 🕱 No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other <i>(specify)</i>	·			-	ay Year
C	at the by th	Physi	9 Unknown	9□ Unknown								
	<u> </u>	by	Part II. Other significant conditions	s contributing to death b	ut not result	ting in the un	derlying cause give	en in Part I.	23e. Did	tobacco use con		f
#26	w require been si should t	ompleted							1 🗆	Yes 2□No	3 Probab	oly 4 Mnknown
(A) 9	has b	nple							24a. Was	an 24b.	Were autops prior to comp	y findings available pletion of cause of
	: The cate ha	Cor							perfe 1 ☐ Yes	ormed?	death?	
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					ath Check only	one		
of o	Phys this ral di	To	1 Tes 2 No 27. Manner of Death	1 Inpatie		R/Outpatient 28b. Time of	AA	4 Nursing i	Home 5 Res			
	ding lh. After funer	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	y Year)	Injury	28c. Injury Work	γaπ ⟨? Yes 2∐No	28g. Describe	how injury occur	rred	
	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inj	ury - At hom	ne, farm, stre			28f. Location (Street and Numi	ber or Rural P	Route Number.
35	al or s afte	ert	4 Homicide	building, et	c. (Specify)				City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death to To the Funerel Director; After completely filled in by the fune	dical	29a. Certifier Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	r examinatio	ledge, death on and/or invi	occurred at the timestigation, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as state and due to th	ed. ne cause(s)
_	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	_ /	1		29c. License	number -		29d. Date signe	ed (Month, Da	ry, Year)
			1. 7.0.	nik	5		D 3	3,54	-	-	- 2/-	nel
1 1	0		30. Name and address of person wh	o completed cause of d			rint)	Λ	100	14	J/ -	OU CARROLL St.
64	Y		Igrahai	,C. Dil		do	M.	U,	PIC	IVC.	100 E.	Carroll St.
	Sta Registi		31. Date filled (Month, Day, Year) JUN 0 1	2004 32. Registr	ar's Signatu	re &	Spork	w (

			1- For Amend Item 20b per FH, G833, 07/21 104dhb Registrer	and Ment	al Hygien	e Pool	22250					
	- · · ·		1. Decedent's Name (First, Middle, Last)	2. Da	ate of Death	ay Year	3. Firme of Death					
	Physici /Medic		James Edward Blackwell	_	une 2							
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death	4	c. County of De	ath					
			Southern Maryland Hospital Clinton	0416-	P	rince G	eorge's					
п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	Min. 8. Da	ate of Birth Month, Day, Yea 24/33	r) 9. B	Country)					
	Director		252-52-3469 Usual Residence of Decedent	2/.	24/33	ET	perton, Ga.					
	ow ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
	Man, -f sh	tor	Md. P.G. Forestvil	lle			1 XYes 2 □ No					
	t within 72 hours after death with the Maryland liene. Then "naturel", or Items 23a or 28a-f show The Medical Examinar must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What C	Country?					
	th wit	aiD	6222 District Heights Parkway 20747	7		U.S.	Δ					
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status		es or No-	14. Race - Arr Black, Wh	erican Indian,					
9	or it	F	1 Never Married 2 Married 1 Yes 2 No 50 No		, 0.0.,		Black					
8	urel',	d by	3 □ Wildowed 4 □ Divorced Year or Dates:									
21215-0036	national and a second	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working	16b.	Kind of Busines	s/Industry					
2	withir iene. r then	E C	Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Work	er	Pı	civate I	industry					
N	be filed tal Hygid d other event,				t, Middle, Maide		and the first of t					
Maryland	d be antat red o	To Be	Wiley Rowe Cur	tis Bla	ackwell							
₹	id 2 should th and Men 27 Is marke traumatic	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			or Town, State.	Zip Code)					
S			Marine T. Dill. 11 /rat C.				3 20245					
5			20a. Method of Disposition 20b. Place of Disposition (Name of	Date	. Forest	V1116 N Location - City o	Town, State					
Baltimore,	permit. Pages of Department of Himportant: If ite eny injury or of once.		1 ⊠Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Maryland Veterans Cent.	7/12/04 7/7/04	4 Che	eltenham	Ма					
薑	nit. Partmoortan		21 Signature of Funeral Service Licensee 22 Name and Address of Facility	v			, Ma.					
ä	permi Depa Impo eny ii		any W. Snile 4925 Burroughs	n & Sor Ave. N	ıs Co]	nc D C	20019					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as			1.10.0.	Approximate					
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Myocardial Infarction									
П			disease or condition resulting in death) MyOCAIGIAI INTACCTION Due to (or as a consequence of):									
			Arteriosclerotic Cardiovascular Disease									
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
	death certificate be executed e attending physician and ad for use as the burial-transit	Examin	that initiated events c.									
Ö,	e exe Sian a uriat-		resulting in death) Last Due to (or as a consequence of):									
68760	ate b	dicai	d									
9 ×	ath certifica ttending phi or use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy									
Вох	attend for us	lan	230. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy		1	23d. Date of de Month						
-	t the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 5 □ Other (specify)									
P.0	that the ded by detact	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 2	3e. Did tobacco	use contribute	o the cause of death?					
Records,	uires sign ld be	d by	Endstage Renal Disease on Dialysis		1 Tes	2 □ No 3 □ F	robably 4 DUnknown					
Ö	The law requires that the ate has been signed by the page 2 should be detache	Completed	Status Post Cardiac Arrest, Tracheostomy		4a. Was an		utopsy findings available					
Re	The lay	E P			autopsy performed?	prior to death?	completion of cause of					
	en: T tificate or, pa	ပိ	Diabetes Mellitus, Hypertension 25. Was case referred to medical 26. Place		☐ Yes 2X N	o 1∐Ye	s 2 No					
⋚	Physicien: this certificaral director, I	o B	examiner?	of Death (Che		6 □Other (Spe	-0.16.1					
ō	a Phy ar this eral d	 	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		escribe how inj		эспу)					
Division	Attending I r death. ector: After by the funer	tio	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ N	No								
Vis	al or Attendi atter death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office				ural Route Number,					
Ö	s afte	Sert	4 ☐ Homicide building, etc. (Specify)		ity or Town, Sta	(0)						
	To the Hospital or a within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier (Check only (2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deat	d place, and du th occurred at t	ue to the cause(s) and manner a	s stated. e to the cause(s)					
	the the the the the the the the the the	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number									
	2 1 2 5	29b. Signature and title of certifier 29c. License number 29d. Date signed (M July 2, 20										
7	90		1 200 017			-1 2,200	<i>,</i> .					
_	LUA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uchechi T. Opaigbeogu, M.D. 6188 Oxon Hill Rd. # 7	701,0xor	ı Hill, M	id. 2074	5					
	Sta Registr		31. Date filed-(Month, Day, Year) 32. Registrar's Signature									

			1 - For Stata Registrar	State of Mary	land / Depa		f Health ar		/giene	14 22360	
	Physici:	an	Decedent's Name (First, Middle, Last	"				2. Date of D Month		3: Time of Death	
6		Medical ALEXANDER BROWN, SR. JUNE 24, 200								.004 12:15A ^M	
<i>j.</i>	Examin	er	4a. Facility Name (If not institution, give	4c. County o							
н	.		11102 QUEENS WOOD 5. Social Security Number 6. Se		yrs. last birthday)	M. If Under 1 Ye	ITCHELLV ar If Under 24	Hrs. R Date of B	irth	NCE GEORGES	
k	Funeral Director		262 64 4306 Usual Residence of Decedent	5, 1940	Birthplace (State or Foreign Country) FLORIDA						
	death with the Maryland me 23a or 28a-f ehow r nual be notified at		10a. State 10b. County	100	City, Town or Lo	cation				10d. Inside City Limits	
	a-1-e	ctor	MARYLAND PRINCE	GEORGES	MITCHELI	VILLE				XXYes 2□No	
	or 28	Director	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of Wh	hat Country?	
	23a	rai	11102 QUEENS WOOD				20721		UNITED S		
	or Ite	by Funeral	11. Marital Status 1 □ Never Married XX Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C		n? (Specify Yes or N Puerto Rican, etc.)		- American Indian, , White, etc. BLACK	
3-UU30	"netural",		15. Decedent's Edu		16a, Dece	dent's Usual Oc	cunation		16b. Kind of Bus		
<u> </u>	n n Media	Completed	(Specify only highest grad		(Give	kind of work do OO NOT use re	ne during most o tired)	of working	Note: Airid of Edg	in o sam dustry	
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and	e file al Hyg othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middl			
	Ments Ments arked	Tof	CHARLIE BROWN				CASS	IE TARBER			
al	ges 1 end 2 should be filed will of Health and Mental Hygien if I Item 27 is marked other thor or other treumatic event, Inst		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	g Address (Str	eet and Number	or Rural Route Num	ber, City or Town, S	tate, Zip Code)	
e, e	s 1 end f Health Item 27 other to		LINDA BROWN / SPO				S WOOD T		MITCHELL		
	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ I	Tellioval from State	Ob. Place of Dispo cemetery, cren	natory or other	1	Date		ity or Town, Slate	
Saltimor	Pa mer ant ury		* 4 ☐ Donation 5 ☐ Other (Specify)) (OAK HILL			JLY 01, 04		AND, FL	
e C	Dermit. Depart Import eny inj		21. Signature of Funeral Service Licens	Vans.	1	+308 SUJ	TLAND R	RAL HOME OAD SUI	TLAND, MD	ND,INC. 20746	
	Physician		23a. Part1. 3h er the disease, or comp shock, if heart failure. List only o Immediate C wase (Final disease or condition	lications that caused the ne cause on each line. RESPIRATO			dying, such as ca	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a cor							
	Examine:	_	Sequentially list conditions,	b. METASTATIO		ALL CEL	L LUNG C	CANCER		10 MONTHS	
	pet Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	isoquence or).						
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):						
00/	ite be ex ysician ne burial	cai		d							
Q	certificate Iding phy Ise as the			u							
gox	eath certificat attending phy I for use as the	M/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		lEctopic pregna			23d. Date	of delivery	
ם.	that the deat led by the attr detached for	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time		Other (specify			Monti	h Day Year	
7	igned by	y Pt	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?	
Hecords	requires that een signed b nould be deta	ed by	CHRONIC OBSTUCTI	VE LUNG DIS	SEASE			XX	Yes 2□No 3	Probably 4 Dunknown	
ပ္ပ	> 0 to	ojet						24a. Wa		ere autopsy findings available	
	sician: The lav certificate has irector, page 2 :	Completed						auto	ormed? de	or to completion of cause of ath? □Yes 2□ No	
Vital	ian: rtifica ctor, p	Be Co	25. Was case referred to medical examiner?				26. Place o	f Death (Check only		7 103 2 100	
O _	d is	To	1 ☐ Yes XX No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA	Other: 4 🗆 Nurs	ing Home 5XXRes	idence 6 Other	(Specify)	
			27. Manner of Death X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yee	28b. Time of Injury	28c. I	yury at Work?	28d. Describe	how injury occurred		
200		cati	2 Accident Investigation 3 Suicide 6 Could not be	an Blue dad			☐Yes 2☐No				
DIVISION	tal or Attensis after deatlal Director:	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, offi	28f. Location City or To	 Location (Street and Number or Rural Route Number, City or Town, State) 			
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one) XX Certifying Phy 2 Medical Exam	rsician: To the best of my iner: On the basis of exa- and manner stated.	knowledge, death mination and/or in	occurred at the restigation, in m	e time, date and i ny opinion, death	place, and due to the occurred at the time	cause(s) and manr , date and place, an	ner as stated. d due to the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier	do.			ense number		29d. Date signed ((Month, Day, Year)	
		1	Bruce	Coam	1 M	2	1355		JUNE 29	, 2004	
r	(10)		30. Name and address of person who c				I CADIMA	I CE NE	IIA CUITNOS	ON DC	
	≪ Sta	to.	BRUCE COOPER, M.] 31. Date filed (Month, Day, Year)			O NORTH	1 CAPITA	L ST. NE	WASHINGTO	JN, DC	
*	Registr		JUL 0 2 2004 1	32. Registrar's S	parle						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Year **Physician** 14 Pauline Nellie Barckley June 2004 10;25 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner 1512 Jersey Road Salisbury Wicomico If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Days Months 1□ M 2**X**F Yrs. 10 Director 093-12-5007 90 1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, it a Madical Examinar must ha marked as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Wicomico Maryland Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1512 Jersey Road 21801 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Domestic None 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Hammond Thomas Bounds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1512 Jersey Rd.Salisbury, Md.21801 Annabelle Morris (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 118 Springhill Mem.Garden 4 ☐ Donation 5 ☐ Other (Specify) *oy* Hebron,Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Stewart Funeral Home 821 West Rd.Salisbury, Md.21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical mo. Examiner Due to (or as a consequence of) Examiner Physician: The law raquires that the death cartificate ba axecuted signed by the attending physiclan and de datached for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) vision of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Y63 24 NU 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 100 erai Director: After this filled in by the funeral di 28a. Date of Injury (Month, Dey Year) Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitai or Attanding 1 Netural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completaly filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 17, 2004 D0014314 30, Neme end address of person who completed cause of death (Item 23e) (Type, Print) PANPI KLUh. 145 E Canell Strut, Solisbury, M.D. 21804 9 31. Dete filed (Month, 32. Registrer's Signature State 2004 Registrar

DHMH 16 Ray 6/95

		1 - For State Registrar	State of Mary	rland / Depa <i>Cer</i>	rtment of H	lealth and I Death		giene	04	223	62			
3 8	2	1. Decedent's Name (First, Middle, Las	")				2. Date of Dea Month	ith Day	Year	3. Time of [
Physicia /Medic		David Bennett,	Sr.				04	05 20	004	1:45	A M			
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1	4c. County						
		Holy Cross Hospi	tal		Silver If Under 1 Year	Spring If Under 24 Hrs.	0.0-14.0-4		gomer					
Funeral		5. Social Security Number 6. Se 251-44-0354	TH OFF	yrs. last birthday)	Months Days	Hours Min.	(Month, Da)	r, Year)	Cour	place (State or				
Director		Usual Residence of Decedent	. /	72 Yrs.			09 28	31	Spart	enburg	, 5.0			
and		10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City	y Limits			
Mary f sho	ō	D.C.		Washing	ton					12 Yes	2 🗌 No			
28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?				
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene than "natural", or Items 23a or 28a-f show ant. In Medical Exactine Invitation Incitional Incitonation Incitona		4220 7th. Stree	r N W.		2001	1	:	USA						
death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. V	Vas Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Ra	ce - Americ					
after or Ite	Ī	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No		l ☐ Yes 2 🖾 No		0 1 110411, 010.)	1	y: Bla					
ours raff,	d by	3 ☐ Widowed 4X Divorced	Year or Dates:											
72 h natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occup kind of work done	during most of wor	rking	16b. Kind of B	lusiness/In	dustry				
vithin ne. hen	m Id	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		OO NOT use retired CNOWN	"		D.C. Go	vern	nent				
be filed within 72 ho stal Hygiene. od other than "natus event, It's Meulical		9th. 17. Father's Name (First, Middle, Last)		Ullr	CITOWIT	18. Mother's Nan	ne (First, Middle,	Maiden Sumai	ne)					
od of	Be	Clayton T. Benne												
should and Men marke umatic	2	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street		MAe PAr		. State. Zic	Code)				
d 2 s th an th an treu		Christine Bennet			Metzerot									
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event. If a Magnes.		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location						
Pages nent of I ant: If its		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specify		•	natory`or other plac	1	0.4		3.63					
artme ortan injur		21. Signature of Funeral Service Licen	· · · · · · · · · · · · · · · · · · ·	HArmony M	. Name and Addre	ss of Facility Man	-04	Landove	r, MI					
permit. Departr Imports any inj		Lama &	-00											
	-	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.												
Marin Market		shoek, or heart failure. List only Immediate Cause (Final							d.	Onset and D				
Pnysician /Medical		disease or condition resulting in death)	Due to (or as a co						-					
Examiner			Chronic (Obstructi	ve Pulmor	nary Dise	ease							
	ē	Sequentially list conditions if any, leading to immediate	Due to (or as a co		ve razmo.	uary Dis								
uted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Congesti	ve Heart	Failure									
sicien and		resulting in death) Last	Due to (or as a co	, ,										
ate be ex hysicien the burial	Ical		d. Hypertens	sion										
leath certifica attending ph	P	IF FEMALE:							-					
ith ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy	1			ate of delive	•	'ear			
e dea he at led fo	Sici	in the past 12 months? 1 Yes 2 No	4□Pregnant at tim 9□Unknown	e of death 5	Other (specify) _				Oliver	<i>52,</i> .				
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w requir been si should	ted	Sleep Apnea												
e law has b	nple.	Obesity	•				24a. Was autop	sy	prior to co	opsy findings a impletion of ca	vailable luse of			
ding Physicien: The Ih. h. After this certilicate ha	Completed		·				1 ☐ Yes	rmed? 2 🖾 No	death?	2□ No				
cien: ertilic ector,	Be	25. Was case referred to medical examiner?	Linea itali		04		ath (Check only o	ne)						
hysi this c	은	1 ☐ Yes 2X No		2 ER/Outpatier		4 🗆 (40) 3)(19)	Home 5 Resid			(y)				
ing F	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Wor	yat rk? Yes 2 □ No	28d. Describe	low injury occu	1180					
tend leath tor: /	Certification;	2 Accident investigation 3 Suicide 6 Could not b		At home from the		195 2 110	28f. Location (5	Street and Num	her or Bur	al Route Numl	her			
or Al lifter of Direct in by	Ē	4 Homicide determined	28e. Place of Injury building, etc. (eet, factory, office		City or Tov		Der or Hare	27110010 710771	,01,			
pitel		29a. Certifier 1 XCertifying Ph	ysician: To the best of n	ny knowledne desti	n occurred at the tir	me, date and place	a, and due to the	cause(s) and m	anner as s	stated.				
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Exar	niner: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death occi	urred at the time,	date and place	and due t	o the cause(s)				
o the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)				
F S F Ö		Da - + []	.//	N.O	D4175	2		4-6-04	i					
(6)		30. Name and address f person who	completed cause of deat	h (Item 23a) (Type										
		Bergit Schoellman				, Silver	Spring.	Md. 20	910					
* St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	•		-1							
Regist		APR 1 3 2004	Bleen ,	A 12004	W.									

	For State Registrar	State of Maryland / De	epartment of Health and No Certificate of Death	Mental Hygier	ne
	Decedent's Name (First, Middle, Last,		Torinoato or Dourr	Reg. f	Time of Death
Physician /Medical Examiner	Matthew Lincol		4b. City, Town, or Location of Death	June 28	Day Year 8:40 A. M
Examine.	Southern Maryland	Hospital	Clinton		rince George's
Funeral Director	5. Social Security Number 6. Sec. 1579-60-2680		(ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea 11/5/09	9. Birthplace (State or Foreign Country) Wash.,D.C.
and and	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits
8. 40 Am. r death with the Maryland ems 23s or 28s-f show wirmust be notified at	D.C. 10e. Street and Number	7	Washington		1 ☐ Yes 2 ☐ No
33 or II Dir	2121 34th St.,S.	Е.	10f. Zip Code 20020	10g. C	Citizen of What Country? U.S.A.
0 = =	11. Marital Status 1 Never Married 2CXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White etc. African— Specify: American
Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mental Hygiene. 27 Is marked other then "natural", or traumetic event, the Medical Exam. To Be Completed by F	15. Decedent's Edu (Specify only highest grade	cation = completed) 16a. D. (C. (iii) 16a. D. (C. (iii) 16a. D. (iii) 16	ecedent's Usual Occupation live kind of work done during most of work fe. DO NOT use retired)	16b.	Kind of Business/Industry
213 ad with giene f, the	12th		aw Enforcement	1	U.S. Government
be file oth	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	en Surname)
aryla aryla should to not Meni marker umertic	Samuel Bailey	70 (Print)	Eva But		
man 27 is nor traum	19a. Informant's Name/Relationship (Ty Annie B. Bailey/Wi	fe 212	ailing Address (Street and Number or Rur 21 34th St.,S.E., Wa		
Baltimore, semil. Pages 1 ar appartment of Heal my injury or other bids.	20a. Method of Disposition 1 XBurial 2 Cremation 3 P	OHOVELHOIN STATE	crematory or other place)	Date 20c.	Location - City or Town, State
tinen rient:	* 4 □ Donation 5 □ Other (Specify)		1 Mem. Cem. 7/3/0		itland, Md.
Bal Bal	21. Signature of Funeral Service License Aug W.	Prote	22. Name and Address of Facility H.S. Washington &	Sons Co.,	Inc.
Physician /Medical		ie cause on each line.	4925 Burroughs Ave. enter the mode of dying, such as cardiac of the standard o	or respiratory arrest,	Approximate Interval Between Onset and Death
cate be executed mappysicien and mappysicient and m		Due to (or as a consequence of): Due to (or as a consequence of):	y That wester	• •~	Cholhow
Matthew I Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as the completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23. Car. of delivery Month Day Year
be be be	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2 No 3 Probably 4 Minknown
Mattail Record The law required to page 2 should				24a. Was an	24b. Were autopsy findings available
I Recultive has bage 2 s				autopsy performed? 1 ☐ Yes 2 ☑ №	prior to completion of cause of death?
Vital Ro vital Ro certificate har rector, page	25. Was case referred to medical examiner?		26. Place of Death	h (Check only one)	NO 1 101 105 2 1140
7 5 E E E	1 ☐ Yes 2 ☑ No	ospital: 1 hpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 □Other (Specify)
A E E E	27. Manner of Death 1 Datural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Injur	e of 28c. Injury at	28d. Describe how inju	
Division of Division of Division of To the Hospitel or Attending Physician 24 hours after death. To the Funerel Director: After the Completely filled in by the funeral Medical Certification; T	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specity)		28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
Di Di Di The Hospitel or hin 24 hours afte the Funerel Ditt mpletely filled in	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	ician: To the best of my knowledge, deter: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cause(: ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To the within comp	29b. Signature and title of certifier		29c. License number	29d. D:	ate signed (Month, Day, Year)
- AC	the gradus	22	50454	201	ve, 30,04
	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type Sunt 3-41 &	pe, Print) A. Yazdani, M.	D	
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	11. 101. 101. 101. 10. 10. 10. 10. 10. 1	- (-	

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2004 **Physician** June 23, Willie James Brown 2:57 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park | Months | Days | Hours | Min. | Min. | March | 14,1947 | Laurns, S.Carol 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **∑**M 2 ☐ F Yrs. Director 577-58-1664 57 S.Caroli Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or itams 23a or 28a-1 ehow any injury or other traumatic event, the Mudical Exprends must be notified at once. 10b. County 10d. Inside City Limits 1 Yes 2 □ No Directo Prince Georges Maryland Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1836 Metzerott Road 20783 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th. College (1-4or 5+) Transportation / Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Brown Lillie McGowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

N.E. Washington, DC 20011

20c. Location - City or To David C. Brown, Sr. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2☐ Cremation 3 ☐ Removal from State July 2,2004 Washington, DC 4 □ Donation 5 □ Other (Specify) Glenwood Cemetery 22. Name and Address of Facility 21. Signan e of Femeral Service Latney's Funeral Home 3831 Georgia Ave. NW Washington, DC 20011 234. Part 1. Enter the dis shock, of neart failu Immediate Cause (Final disease or condition resulting in death) If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Interval Between Onset and Death ulmohan **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Olie to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical as ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 1 Inpatrent 3 P/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dey, Year) 2326 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, MD 20912 James K. lightfoot, MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature 2 9 2004 Registra

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 22366 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 08, 1:00A BAKER JUNE 2004 BARBARA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES HYATTSVILLE HEARTLAND HEALTH CARE If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31,1967 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 ☐ F 37 Yrs. Washington DC 578 98 0759 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event, the Medical Examinar must be motified at 1 Yes 2 No Director Prince George's Hyattsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 USA 6500 Riggs Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after all Hygiene.
other than "natural", or Itel 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0036 by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public Schools 12th Attendance Officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H Be Dorothy Monsanto Theodore Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11706 Chantilly Lane Mitchellville, MD 20721 Constance Hines/Foster Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State *4 □Donation 5 □ Other (Specify) Alexandria, Virginia Metropolitan Crematory 6-18-04 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee 20mbkely (yourcotonu 4308 Suitland Road Suitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic (Reak ARCINUMA VULVA **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Linknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Human Immunode Strong Vias 1 Yes 2 No 3 Probably 4 Unknown has been si Completed Acquired immunocle ficiency 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2, No this certificate har ral director, page 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 3 DOA 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certified cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple 4203 Queenbury Rd Hyatbu He MA 20781 A. 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 2 8 2004 Registrar

Natalie Cooke 04-4246 MAN Physician /Medical Examiner Funeral **Director** with the Maryland 28a-f show must be notified at Μd

itams 23g

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filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital Records,

Division

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0 = 6 permit. Page Department o tmportant: If any injury or once.

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unpend item#23a,27,PER ME,C833,7/21/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 28, ^{Day} 2004 COOKE NATALIE REGINA 1456 P M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Prince George's Cheverly 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🕱 F 8/30/52 577 70 6462 Washington DC Usual Residence of Deceden 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 1 Yes 2 No Funeral Director Prince George Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 7400 Aspen Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 Yes 2 XNo Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years Sales Representative Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Nellie Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cooke, Nellie Mother 7400 Aspen Avenue, Takoma Park, Md. 20912
De of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Pk 7/7/04 Landover, Maryland 21. Signature of Fundal Service Licer 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 621 Florida Avenue, NW, Washington D.C. 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Find: Stage Renal Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2X ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

/Medical Examiner

Physician

The law requires that the death certificate be executed burial-transit as the l õ or Attanding Physician: in by the funeral director. after death.

by Physician/Medical Be Certification: To

Medical

27. Manner of Death 5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) June 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

OGAM JUL Registrar

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

within 24 hours a

To tha Funaral C

	Pleas	se Type or	Print in Blac	k Ind	lelible Ink.	Ensure	e All (Copies	Are Leg	ble.	
F		State	of Maryland /	Depa	rtment of H	ealth an	d Me	ntal Hy	giene		
For State Registrar				Cert	tificate of L	Death			Reg. No.	14	22369
1. Decedent's Name	(First, Middle	, Last)					2.	Date of Dea		Your	3. Time of Death
	Mat	tie Pear	1 Faulkner	Ca1	1oway			June :	24, Day 200	4	9:25 P. M
4a. Facility Name (If r	not institution	, give street and n	umber)		4b. City, Town, or	Location of C	Death		4c. County	of Death	h
2207 Ser	nator	Avenue			Distric	t Heig	hts		Prin	ce G	eorges
5. Social Security Nur	irthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birt (Month, Da	th Year 1900	9. Birth	hplace (State or Foreign			
228-30-67	742	1 □ M 2 X F	103	Yrs.	Month Days	110013			er 21,		Virginia
Usual Residence of D	Decedent										
10a. State	10b. County		10c. City, Tov	wn or Loc	ation						10d. Inside City Limits
Maryland	Prin	ce George	es Dis	stric	t Height	s					12 Yes 2 No
10e. Street and Numb	ber				10f. Zip Code				10g. Citizen of	What Co	untry?
2207 Ser		20747	Staf	tates							
11. Marital Status	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Ind Black, White, etc.										
1 □ Never Married 2 □ Married 1 □ Yes 2X No					☐ Yes 2X No	Specify:		,,		b: B1 :	_
3 22 111001100		100101									

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Gunpowder Factory Worker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Schaeffer Cemetery

18. Mother's Name (First, Middle, Maiden Sumame)

600 Kennedy Street, N.W.; Washington, D.C. 20011

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747

2207 Senator Avenue; District Heights, Maryland

July 2,2004

Date

R. N. Horton Company Morticians, Inc.

Caroline

4700 Berwyn House Road; Suite 105; College Park, Maryland

U.S.Dept. of Defense

Christianburg, Virginia

Approximate Interval Between Onset and Death

, 2004

20740

(unknown)

20c. Location - City or Town, State

16b. Kind of Business/Industry

Physician /Medical Examiner

15. Decedent's Education (Specify only highest grade completed)

19a. Informant's Name/Relationship (Type, Print)

(Son & Daughter-in-law)

James W. & Grace N. Calloway 20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State

James Faulkner

College (1-4or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

* 4 ☐Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

8th grade

Director

Funeral

þ

Completed

Be

P

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23s or 28a-1 show any injury or other traumatic event, the Medical Eran.

Baltimore, Maryland 21215-0036

ling physician and e as the burial-trans the attending physician use ŏ detached signed by d be detacl page 2 ÷ filled in by the

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

shock, or heart failure. List or						Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. A + he/. Due to or as a conse		rordiovo	swer dis	rese	Onder and South
Sequentially list conditions, it any, leading to limit additionable cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a conse	quence of j:				
that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregring 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 ☐ Ectopic			23d. Date of del Month	ivery Day Year
Part II. Other significant condition	s contributing to death but not re	sulting in the underlying	cause given in Part I.			the cause of death?
				24a. Was an autopsy performed?	prior to a	utopsy findings availab completion of cause of 2 No
25. Was case referred to medical			26. Place of D	eath (Check only one)		
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ [OOA Other: 4 Nursing	Home 5 Residence	6 □Other (Spec	cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2 No	28d. Describe how inju	ury occurred	
3 Suicide 6 Could no 4 Homicide determin		nome, farm, street, factorify)	ory, office	28f. Location (Street a City or Town, State	and Number or Ru te)	ural Route Number,
	Physicien: To the best of my kn xaminer On the basis of a min and manner stated.					
29b. Signature and title		2	9c. License number	29d. D	ate signed (Monti	h, Day, Year)
· CAH	1		07638	7 Ju	ine 25	2004

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State

Registrar

nin 24 hours after deal the Funerel Director:

within 24 hou To the Fune completely fi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc R. Shepard, 31. Date filed (Month, Day, Year)

JUL U I ZUU4

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Monroe Cannon James 7:40 A. M June 25 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kensington Nursing & Rehabilitation Center Kensington Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 90 Director 238-20-8067 March 25,1914 North Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other then "netural", or items 23a or 28e-f shov other treumstic event, the Medical Extensional rust be notified at 1X Yes 2 □ No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 610 Emerson Street, N. W. 20011 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ifiled within 72 hours after I Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 21 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber Barber Shop 9th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, importent: If item 27 is marked othe any injury or other treumatic event, page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sampson S. Cannon Lena Moore 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Correne S. Killette Cannon (Wife) 610 Emerson Street, N.W.; Washington, D.C. 20011 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 3,2004 20c. Location - City or Town, State Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) R. N. Horton Company Morticians, Inc. 21. Signature of Funeral Service Licensee anamak 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5day men mon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š been signe should be 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s has autopsy performed? 2X No 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 X No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation nours after death nerel Director: / filled in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical holetely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 28, 2004 DO0535 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daphna Henkin, M.D.; 2309 Shorefield Road; Wheaton, Maryland 32. Registrar's Signature 31. Date filed (Month, Bay Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 2 gay **Physician** MARCUS LINDSEY COATES 1142 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner beorge's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 214-23-6446 1 XM 2 ☐ F 17 0971371986 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No MD Prince Georges Director Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or 4302 Townsley Avenue 20748 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2☐No 1X Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: þ If Yes, Give Year or Dates: Specify: Blaćk 3 Widowed 4 Divorced "netural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 11th .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tent; if Item 27 is marked other th jury or other traumatic event, Ita Student Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Floyd Lindsey Coates Marva Bruce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Floyd L. Coates - Father 11619 Laurel Bowie Road; Laurel, MD20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Riverdale Crem. 1 ☐ Burial 2XXX remation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 06/28/04 permit. Page Department of Important: If eny injury or Riverdale, Maryland Robert O. Freeman Funeral Services, Inc. 21. Signature of Funeral Service Licensee Oxenda Runa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cunshot wound to Itead **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?

Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this in by the funeral 28d. Describe how injury occurred Shat homself in head 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? After 5 Pending investigation 1 Natural June 17 2004 1750 M 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4302 Town State 24 hours after on Funeral Direc 4 Homicide None Realy 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1005 3001 31. Date filed (Month, Day, 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

JUN 3 0 2004

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]	RJ		1 - State Registrar			,		rtificate of				2004	22372
	A95.	7	1. Decedent's Name	First, Middl	e, Last)					2. Date	of Death		3. Time of Death
	Physici /Medi		•	Tomar	Enrique	Camer	on			June	26,	2004 Year	1926 P.M
	Examir		4a. Facility Name (la	not institution	n, give street and nu	ımber)		4b. City, Town, o	or Location of	Death		4c. County of Oe	ath
	. *				ton Hospi	tal		Fort Wa	ashingt	ton		Prince (George's
	Funeral		5. Social Security N		6. Sex 1XIM 2□ F	7. Age (In y	rs. last birthday	If Under 1 Year Months Days		4 Hrs. 8. Date	of Birth h, Day, Yo	9. B	inthplace (State or Foreign Country)
	Director		213-17-07		IZQIM ZUF		19 Yrs.			Feb.	20,	1985 Wa	sh, D.C.
	and		Usual Residence of 10a. State	10b. County		10c.	City, Town or L	ocation					10d. Inside City Limits
	Maryl f sho	0	Maryland	Princ	e George			hington					1⊈ Yes 2 □ No
	the N 28a-	rect	10e. Street and Nun		000180			10f. Zip Code			100	. Citizen of What (
	with se or		5778 Ev		Place			Tot. Zip Code	20744			nited Sta	
	72 hours after death with the Maryland natural', or Itams 23s or 28a-f show Alcal Examinat must be notified at	by Funeral Director	11. Marital Status			edent Ever in	1 U.S. 13	Was Decedent of I		n? (Specify Yes		14. Race - An	
10	fter o	F	1 X Never Marri	ed 2□ Mari	Armed F	orces?		Was Decedent of H If Yes, specify Cub	an, Mexican,	Puerto Rican, etc	:.)	Black, Wh	
93	urs a	by	3 Widowed	4 Divorced	If Yes, G Year or D	ive Dates:		1 ☐ Yes 2 ☒ No	Specify:			Specify: B	lack
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7	ar th	20	12				St	udent				School	
nd	al Hy d oth	Be	17. Father's Name (Last)					s Name (First, M.		den Surname)	
<u> </u>	Men Men arke	2	James Ca	meron					Mary	F. Als	ton		
Maryland 21215-0036	2 sho and ls m		19a. Informant's Na					ng Address (Street					
2	and ealth n 27 nartr		Mary F. C		/Motner			Everhart	Place;	Ft. Wa	shing	gton, MD.	20744
ore.	of H of H If ital		20a. Method of Disp		3 □Removal from	State	cemetery, cre	osition (Name of matory or other pla		Date		c. Location - City o	
Ë	Pag ment ant: ury c		` 4 □ Donation			Re	surrect	ion Ceme	tery¦Ju	ıly 2, 20	04 C	linton,	Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23s or 28a-f show any injury or othar traumatic evant, the Medical Exeminating must be notified at ance.		21. Signature of Fu	neral Service	Licensee	21	00 2	2. Name and Addre	ss of Facility	Pope F	inera	1 Homes	
-	205 29		-	wa	2.0%	ike	er			Forest	File	ro Pike	0747
8			23a. Part1. Enter the shock, or hear	ie disedse or t failure. List	complications that only one cause on	caused the de each line.	eath. Do not en	ter the mode of dyir	ng, such as ca	ardiac or respirato	ry arrest,		Approximate Interval Between
	Physician		Immediate Cause (disease or condition	Final	Gun	shot	wound	(5(z) of	abdor	nen an	dru	9ht aver	Onset and Death
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Вох	ath c	ian/	23b. Was decedent in the past 12 i			oirth 2 🗆 F	etal death 3	Ectopic pregnancy	/			23d. Date of de Month	livery Day Year
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of	di S	은	1v Yes 2□				XER/Outpatier		4 Nursi	ing Home 5 ☐ F	Residence	6 □Other (Spe	ecify)
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Division	or Attanding uter death. Diractor: After in by the fune	cati	2 Accident 3 Suicide	investig 6 ☐ Could r	ot be	104	6:50	1	Yes 2 No		villa	+ Shot	
\leq	l or Attand after death Diractor:	THE STATE OF	4 Homicide	determ	ined 288. Place	of Injury - Ating, etc. (Spe	city)	eet, factory, office		28f. Location	n (Street Town, St	and Number or R	Wertpart Place
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	To the Hospital or Attan within 24 hours after deat To tha Funaral Diractor: completely filled in by the	edical	(Uneck only	1∐ Certifyin 2∑ Medical	g Physician: To the Examiner: On the b	asis of exami	nowledge, deat ination and/or in	n occurred at the tin vestigation, in my o	ne, date and p pinion, death (place, and due to occurred at the ti	the cause	a(s) and manner as	s stated. e to the cause(s)
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L	(3)		30. Name and addre	71.	who completed dus	e of death (It	ет 23а) (Туре,	111 Pe	nn Str	eet. Bal	timo	re, Marv	land 21201
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	Sta Registr			1 3 0 2		egistrar's Sig	k for	S. I					

			1 - For State Registrar	State of	Maryland	•	artment tificate			and N	fental Hy	/giene	20	04	223	37:
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7	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City,	Town, or	Location o	of Death	JUNE		County	2004 of Deeth	3:10P	
			DOCTORS COMMUNITY				William		ANHAM						RGES	
	Funeral Director		5. Social Security Number 6. S 578 18 7481	ex □ м 2XXF 7	'. Age (In yrs. las 9(If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D MAY 17	rth ay, Year) 10	1.4	Coun	lace (State or itry) HINGTON	
	9		Usual Residence of Decedent					1			rial 17	, 17.	14			
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	the N	Funeral Director	MARYLAND PRINCE (10e. Street and Number	GEORGES	LAI	MAHI	10f. Zip	Code				10g. Cit	izen of W	/het Coun		
	h with 23a or	ai Di	9885 GREENBELT ROA	AD #203				207	706			UN	ITED	STAT	ES	
	lams lams	Juer	11. Marital Status	Armed Ford		13.	Was Deced	ent of His rly Cubar	panic Orig	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	0-		- Americ	an Indian, etc.	
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215-0036	be filed within 72 hours after death with the Marylar lat Hygiene. d other then "neturel", or items 23e or 28e-f show event, the Medical Exemptor must be notified at	ted	15. Decedent's Ed	ducation			dent's Usua			of word	in a	16b. K	ind of Bu	siness/Inc	dustry	
2	within 7 ene. than "r he Wed	Completed	Elementary/Secondary (0-12)	College (1-		life.	kind of wor DO NOT us	e retired)	-		•					
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Maryland		To Be	WILLS J. AIKEN								LE BRA			-,		
ary	s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rur	al Route Numb	per, City o	r Town, S	State, Zip	Code)	
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פֿב	Pages 1 and the pages 1 and th		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐		tate cen	netery, cren	sition (Nem natory or ot	her place	1		Dete			City or To		
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1	- (10)		30. Name and address of person who 31. Date filed (Month, Day, Year) JUN 2 8 2004	7209	of death (Item 2	3a) Type.	Print) ER	PKI	YW	GR	EEN	SEL	7	MI	20-	770
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DHMH 17 Rev 1/2001

	**		For State Registrar	State of Marylar	nd / Depa	artment of H	lealth ar		ental Hyg	giene	04	223	74
			1. Decedent's Name (First, Middle, Last)		-			2	2. Date of Dea Month	ith Day	Year		of Death
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ì	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	r Location of I	Death			unty of Death		
_		•	104 Nottingham Roa 5. Social Security Number 6. Sex		. last birthday)	Elkton	If Under 24	Hrs. 6	Date of Birth		ecil	nlace (Stat	e or Foreign
	Funeral Director			M 21XF 88	Yrs.	Months Days		Min.	B. Date of Birth (Month, Day JAN 11,	Year) 1916	Cou	ntry)	
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	with t			- d		21921					ted Sta		
	ns 23	Funerai	104 Nottingham Roa	2. Was Decedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin	n? (Spec	ify Yes or No-		Race - Ameri	can Indian	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be multipled at		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	Specify:	Puerto Ri	ican, etc.)		Black, White, pecify:	etc. ite	
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3	2 should be and Menta Is marked sumatic ev	ြ	William Harrison S 19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Street						o Code)	
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Baltimore,	of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		cemetery, crei	osition (Name of matory or other place	эe) ¦	Da July		20c. Local	tion - City or T	own, State	
	t. Pages tment of tent: If it		`4 ☐ Donation 5 ☐ Other (Specify)		ouldén emetery			2004		Elkt	on, Mar	ylan	d
ga	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service License	Hickor	H.	2. Name and Addre icks Home 03 W. Sto	for F	uner Stre	als, P	.A. kton,	Maryl	and 2	1921
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea a cause on each line.	ith. Do not en	ter the mode of dyin	ng, such as ca	ardiac or	respiratory are	est,		Approxin Interval E Onset an	Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	e My	ocardial =	n fare	tion				_	Siste
	/Medical Examiner		1	Due to (or as a conse	quence of):								
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):								Υ
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
760,	ate be executed hysician and he burial-transit	I Ex	resulting in death) Last	Due to (or as a conse	quence of):								
6876	cate b	dical	d.										
×	ding as	√Me	IF FEMALE: 23	ic. If yes, outcome of pregr	nancy					230	. Date of deliv	erv	
Вох	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	′			250	Month	Day	Year
0	by the	hys	9 Unknown	9∐ Unknown									
	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Other significant conditions conf		sulting in the u	ndertying cause giv	en in Part I.			W.	contribute to t		
ord	w require been signature	ted	Hyperten	Sign				-	1 U Y	es 2 🖎	√o 3 ☐ Prol	pably 4	Unknown
Records,	has by	Completed							24a. Was a autop:	sv	4b. Were auto prior to co death?	psy finding impletion o	s available cause of
	ysicien: The l is certificate ha director, page									med? 2/2 No	1 Yes	2 No	
=	sicier certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	TEB/Outpotion	oth Oth	0.5		Check only or		Other (Specia	4 -1	
o	ding Phy h. After this funeral d	-	27. Manner of Death	28a. Date of Injury	28b. Time o	IL 3L DOX	4 🗆 140131		d. Describe h			(Y)	
0	nding ath. r: Afte e fun	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No						
Division of Vital	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, p	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, strify)	reet, factory, office		28	If. Location (S City or Tow		lumber or Run	al Route N	umber,
	Hospite 24 hours Funerel stely fille	edical C	29a. Certifier 1 ☐ Certifying Phys (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and p pinion, death	place, an	d due to the c	ause(s) an late and pla	d manner as s ace, and due t	tated. o the cause	9(S)
	ro the within Fo the Somple	Me	29b. Signature and title of certifier			29c. Licens	e number				igned (Month,)
	,- 0		> 14. Harka	2 ~77		7/4	53/1	4		7 why	11,20	04	
	1		30. Name and address of person who cor				*						
	1		H Furkas	np Un	ion Ho	F. E Ikt	on, /	JD	219	2/			
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	, ,		3					
DH	MH 17 Rev 1/2		JUL 1 6 2	004 Bener	me /	Spa	the	-				-	
				•		-							

		1	FOR	State of Maryland / Depa 23a&b PER PHY C83 37			al Hygien Reg. Ņ		22375
			. Decedent's Name (First, Middle, Last)	Z. ARIJ TIR THE COSS	77.10707 011	2. Ua	te of Death onth Da	y Year	3. Time of Death
	Physicia	_	Jesse Burt	Collier Sr.		May		· .	7:50 AM M
	/Medic Examin		a. Facility Name (If not institution, give st		4b. City, Town, or Locatio	on of Death	40	. County of Death	
	LXammi		St. Mary's Nursing	Center	Leonardtown	n	5	t. Mary'	S
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		der 24 Hrs. 8. Da	te of Birth onth, Day, Year	9. Birth	place (State or Foreign intry)
	Director		220 - 34 - 3057	M 2□F 90 Yrs.	World Days Tious		3, 191		ginia
	ס		Jsual Residence of Decedent						10d. Inside City Limits
	how		10a. State 10b. County	10c. City, Town or Lo					1 ☐ Yes 2 No
	e-f s	g [Maryland Calvert	Lust	-				
	15 th	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	intry?
	th wi		522 Gunsmoke Trail		20657			ted Stat	
	ems ems	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. 13. \ Armed Forces?	Vas Decedent of Hispanic (f Yes, specify Cuban, Mexic	Origin? (Specify Yeican, Puerto Rican,	etc.)	 Race - Amer Black, White 	
9	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23e or 28e-f show the M. vicel Examiner must be ricitified at	F	1 Never Married 2 Married	1 TYes 2 No 1932-	I ☐ Yes 2√√No Spec	city:		Specify: Whi	te
21215-0036	"naturel", or	d by	3 √Widowed 4 ☐ Divorced	Year or Dates: 1953	Table 11 and Occupation		165		
2	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	tent's Usual Occupation kind of work done during m DO NOT use retired)	nost of working	160.1	Kind of Business/li	ndustry
121	vithin ne. han	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		1	***	1 M	
S	be filed within 72 hc lal Hygiene. d other than "natul event, Ille M. Jical		17. Father's Name (First, Middle, Last)	Avia	tion Metalsm	1 E N other's Name <i>(First</i>		n Sumame)	
ano	be fi	Be				ude R. Ro			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Men	은	Jesse Ward Collier		ng Address (Street and Nur				in Code)
Jai	12 st		19a. Informant's Name/Relationship <i>(Typ</i> Jesse Burt Collier		Gunsmoke Tra:				
	1 and Health em 27 ther tr		20a. Method of Disposition			Date		ocation - City or 1	
0	Pages 1 and 2 should hent of Health and Men int: If item 27 is marke iry or other treumstic		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	sition (Name of natory or other place)				
Ë	tmen tent tent	1	'4 Donation 5 □ Other (Specify)		el Cemetery 2. Name and Address of Fa	5-5-2004	HOT.	Lywood, M	laryLand
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre <u>once</u> .		21. Signatur, of Funeral Service Licente	1/1/1/5/13/12/1		Dwinafi	eld Fur	neral Hom	ne, P.A.
_	70 % a 0		11 wy Ris	ations that caused the death. Do not ent e cause on each line. RENAL I	2955 Hollywo	od Road I	eonard	own, Md	20650 proximate
			shock, or heart failure. List only on	e cause on each line.	FATLURE	as cardiac or resp	natory arrest,		Interval Between Onset and Death
	Priysician	1	Immediate Cause (Final/ disease or condition resulting in death)	Cardia	-CV7CS	+-			
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	DEHYDRATION	vo.			
	Examine		Sequentially list conditions, b	Due to (or as a consequence of):	10 101			-	
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ration of A	lure.				
	ecution and I-tran	хап	that initiated events cresulting in death) Last	Due to (or as a consequence of):	7,00				
8760,	cate be executed physicien and the burial-transit	ai E							
87	cate o	dicai							
9	certific nding p	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy				23d. Date of deli	verv
Вох	death c e attend ed for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 [Ectopic pregnancy Other (specify)			Month	Day Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown					
P.0	requires that the death certifii een signed by the attending I hould be detached for use as	Physician/Me		tributing to death but not resulting in the u	inderlying cause given in Pa	art I. 2	3e. Did tobacco	use contribute to	the cause of death?
S,	Se us	by	Tur, ii. Ollor olgrinoani	<u>.</u>	, ,		1 🗌 Yes	2 □ No 3 □ Pro	obably 4X_Unknown
Records,	w require been sign	Completed					4a. Was an	Oth Word av	tangu findinga nyayahla
ec		pldu					autopsy performed?	prior to d	topsy findings available completion of cause of
	The law ate has page 2:	Son				1	☐ Yes 2√☐ N		2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	la controlla		Place of Death (Che	ick only one)		170 7 E - 12 - 1 - 1 - 1 - 1 - 1
of V	shysic this call dire	2	1 L Yes 2 XINO	lospital: 1 Inpatient 2 ER/Outpatie	44	Nursing Home			pify)
n	fe fee	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?		escribe how in	ury occurred	
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ž	or Att	Ē	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specity)	reet, factory, office	201. C	ity or Town, Sta	ite)	na riodie riamosi,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Ce		T. E. E. I. I. I. I. I. I. I. I. I. I. I. I. I.	de	to and class and d	in to the caus:	(c) and manner	stated
	Hospitel	ledical	(Check only 2 Medicel Exemi	sicien: To the best of my knowledge, dear ner: On the basis of examination and/or in	nvestigation, in my opinion,	death occurred at	the time, date a	nd place, and due	to the cause(s)
	To the h within 2 To the i	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License numb	ber	29d. [ate signed (Monti	n, Day, Year)
	To To Cor		250. Signature and the or certified	ah				5.600	
			7 000		D47066			3 -	
				ompleted cause of death (Item 23a) (Type		mardtown	Md 2	0650	
			Avani D. Shan, M. 31. Date filod (Month, Day, Year)	D., 22650 Cedar Lan	e court, neo	marucown	, riu Z	0000	
		ate rar	MAY 6 2004		off 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Year **Physician** 8, 2004 Letha Clara Comegys 7:05 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 10, 1905 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 21 F Mary Land 99 218-80-5401 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 Is marked other than "natural", or Iteme 23s or 28s-f ehor traumatic evant, the Modical Examiner must be notified at Frederick Frederick Maryland 1 Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 U.S.A. 1421 Taney Ave., Apt. 307 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes No It Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: ۵ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lipity or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Levin Thomas Beauchamp Sarah Elizabeth Dykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 Taney Ave., Apt. 102, Frederick, MD 21702 Mr. Wallace L. Comegys, son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hyattstown Methodist Cemetery July 12, 2004 Hyattstown, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, days leading to initial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a dishequence of) Due to (or as a consequence of). Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perfor 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 6876 signed by the aid this certificate has al director, page 2 To the Funaral Director: After th completely filled in by the funeral death. 6 within 24 hours a To the Funaral L fo the Hospital

28a-f ehow

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D-1397 July 9, 2004

e of death (Item 23a) (Type, Print)

Robert L. Kaufmann, M.D. 300 T 32. Registrar's Signature 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year)

State Registrar

			For State	i icase	State of	Marylan	d / Depa	artmer	t of H			-		2001	00077
	-		Registrar				Cei	runcai	e or i	Dealli		2. Date of D	Reg. N	9 11 13	3. Time of Death
-	Physici	an		e (First, Middle, Last								Month	D	ay Year	
	/Medic	al	HEL									June		2004	12:08P T
7	Examin	er		f not institution, give				4b. City	Town, or	r Location of	of Death			c. County of Dea	
				hitehol			lana bindada. 1	Lar	go r 1 Year	If Under	24 Hrs	R Date of F			George Ls
	Funeral		5. Social Security N	11	X □M 2対F	Age (In yrs.	iast birtnday) Yrs.	Months		Hours	Min.	8. Date of E	Day, Yea	020	Country)
	Director	-	411-40- Usual Residence of			83				J		Decembe	F 0/1	920 Ter	inessee
	and and		10a. State	10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many f sh	ō	IN	Monroe		Mac	lisonvi	lle							1⊈Yes 2□No
	158 the	rec	10e. Street and Nu	mber				10f. Zi	p Code				10g. C	itizen of What C	Country?
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show ta Madical Examinational te notified at	Funeral Director	619 McGe	e Street				37	354				US	SA	
	ms 2	era	11. Marital Status		12. Was Deced	ent Ever in U	.S. 13.	Was Dece	dent of H	lispanic Ori	gin? (Spe	cify Yes or I Rican, etc.)	No-	14. Race - Am Black, Wh	
(O	or the	교	1 Never Marr	ied 2□ Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	IX No	1	1 Yes		Specify:		noan, etc.)			
ලි	ral', c	l by	3 🖾 Widowed	4 Divorced	Year or Dat	es:		10 163	2/21/140	орвену.				Specify: B1	ack
ည	72 hc natur	etec	(Spec	15. Decedent's Ed	ucation de completed)		16a. Dece (Give	kind of w	ork done	during mos	t of workir	ng	16b.	Kind of Busines	s/Industry
2	thin ser.	Completed	Elementary/Seco		College (1-4	lor 5+)		DO NOT	ise retired	d)			D.,		
7	filed wi Hygien other th	S	8	(First Middle 1 act)			Domes	SLIC		18 Moth	ar's Name	(First Midd		ivate I en Sumame)	noustry
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<u> </u>	ould be Mental Marked o	ဥ	James Mc		0.111		105 11-11		- /24-0-04				than Cit	or Town, State,	Zia Coda)
<u>Ja</u>	2 sho			ame/Relationship (7	ype, Print)										Zip Code)
0	l and lealth m 27 her t		John Dye			20b. F	13200 Place of Dispo			Im Dr		go, Mate		20774 Location - City o	or Town, State
0	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Examination and or other traumatic event, the Madical Examination.		1 🗆 Burial 2	Cremation 3 🖸		ate	semetery, cre	matory or	other plac	-	06/20	/2004		200	
Ë	tmen tant: ijury			5 Other (Specify		DIE	reley-I							isonville	·
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 li sny injury or other tra 90029.		21. Signature of	uneral Service Lice	old-					ss of Facili vania		ar Hill uitland		eral Home, 20746	Inc.
	9.3		23a. Part . Enter	the disease, or compart failure. List only	olications that ca	used the deal	h. Do not en	iter the mo	de of dyir	ng, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between
D. Salar	Physician		Immediate Cause disease or condition	(Final			rdial	info	rati	on					Onset and Death
	/Medical		resulting in death)		Due to (o	r as a consec	uence of):	TIITG	CCLI	OH-					minutes
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Вох	death certificate I e attending physi od for use as the t	Physician/Medi	23b. Was deceded			th 2 Feta	al death 3	□Ectopic :		у				23d. Date of d Month	lelivery Day Year
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P.0	d by t	Phy		ificant conditions o	ontributing to de-	ath but not re-	sulting in the	underlying	Cause Oli	ven in Part	1	23e. Di	d tobacc	o use contribute	to the cause of death?
Ś	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other sign	incam conditions o	onthibating to do	attr But not ro.	Juling in the	andonying	oause g.				⊒ Yes		Probably 4 X Unknown
of Vital Record	w require been sign	Completed													
ec	e law has b	npie										24a. W	as an itopsy informed?	prior t	autopsy findings available o completion of cause of
H =		S						_				1 ☐ Yes			
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case refe examiner?	erred to medical	Hospital:				0**			(Check on			G ! D !!
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	ing F	on	27. Manner of Dea 1 XNatural	5 Pending	1	f Injury n, Day Yeer)	28b. Time Injury	M	28c. Inju Wo	rk?]Yes 2.[LOU. Descrit) 0 110₩ 111	ilary occarred	
Division	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not b		of Injury - At h	oma farm o					28f Location	(Street	and Number or	Rural Route Number,
Ξ	or At fter of lirect in by	E	4 Homicide	determined	buildin	g, etc. (Spec	ify)	areet, racit	ny, omce				Town, St		riarar riodio riambor,
	To the Hospitel or Attending Phwitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier	1 ☐ Certifying Ph	veician: To the	hast of my be	owledge des	th occurre	d at the ti	me date a	nd place	and due to t	he cause	(s) and manner	as stated
	Hos 24 ho Fund Telly f	Medical	(Check only one)	2 Medical Exe	niner: On the ba and mann	sis of examin	ation and/or i	nvestigation	on, in my	opinion, de	ath occurr	ed at the tim	e, date a	and place, and d	ue to the cause(s)
	within 2 To the complet	Med	29b. Signature an	d title of certifier	. (/	or statod.		2	9c. Licen	se number			29d. [Date signed (Mo	inth, Dey, Year)
	7 × 7 8			10-60	N.K.	NA			D5679	9			06,	/28/2004	4
0 10	(6)		30 N	dress of person who	completed source	o death (to	m 23a) /Tues	Print\				-			
VE	(4)			e A. Roble					South	Towe	er #4	21	D .	0 2001/	12075
1		ate	31. Date filed (Mo			egistrar's Sigr	ature		CL/ 1	.∀• Ц• _]	wabiil	ngron	<u>, 1) • (</u>	ZUU_I	J-7312
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		1	For State Registrar	State of	Maryland			t of Health e of Deat			giene Reg. No.)	2001.	00070
Phy	ysicia		Decedent's Name (First, Middle, II) HARVEY	_ast)		DA	VIS			2. Date of De Month	ath Day	Year 2004	10:53 A M
	ledica amine	r 4	a. Facility Name (If not institution, g	ive street and num	ber) T HOS	PITAL		Town, or Location				County of Death	MERY
Fun-			-10/1		7. Age (In yrs. I		If Under Months		ier 24 Hrs.	8. Date of Bir (Month, Da 05 25		1	olece (State or Foreign http) Holly N.C.
land	wi.	-	Jsual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
e Mary	Tilled	Director	DC		Wa	shing	_				10a Citis	zen of What Cou	1 ☑ Yes 2 ☐ No
with th	200		10e. Street and Number	oot N E			10f. Zip	0002				JSA	imy r
ING 21215-UU35 be filed within 72 hours after death with the Maryland tal hygiene. do other than *natural*, or ttems 23a or 28a-f show	acciner mus	by Funerai	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Dece Armed For	2 🔼 No	'	Was Dece	dent of Hispanic only Cuban, Mex	ican, Puerto	pecify Yes or No Rican, etc.)) 1	14. Race - Ameri Black, White, Specify: Blac	etc.
21215-0036 d within 72 hours at giene. er then "naturel", or	Medical Ex	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Education		(Give life.	dent's Usu kind of wo DO NOT u	al Occupation rk done during r se retired)	nost of worl	king		nd of Business/Ir	ndustry
Maryland 2127 of 2 should be filed within the and Mental Hygiene. 27 1s marked other than	s event, the	Be	8th. 17. Father's Name (First, Middle, La	ast)		Lau	orer			ne (First, Middle			
aryland should be and Mental	umati	၉	John Davis 19a. Informant's Name/Relationshi	o (Type, Print)				(Street and Nu	mber or Ru	ral Route Numb		r Town, State, Zi	
and 2 and 2 ealth a	ner tra		Marie Silver/I	aughter	20h B	-			t N.E	. Washi		n , D.C.	
Pages 1	or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State 1	lace of Dispo emetery, crea rt LIn		other place)	6-28			ntwood,	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men importent: If item 27 1s marke	any injury once.		21. Signature of Funeral Service Li			2:	2. Name a	nd Address of Fa	acilityMar	shall's	Fun	eral Hom , D.C. 2	ie .
Physi /Mec Exam	dical iner	Examiner	23a. Part / Enter the disease, or conditions, or heart failure. List of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. My Due to (b. PUL) Due to (c	or as a consequence or a consequence or a	UP A PY uence of):							Approximate Interval Between Onset and Death
Box 6: death certific	for use as	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	come of pregni	ancy	□Ectopic p					23d. Date of delin	very Day Year
Pat the bat th	be detac	þ	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the i	underlying	cause given in P	art I.		tobacco u		the cause of death?
I Records, The law requires t	page 2	Completed								24a. Wa auto per 1 🗆 Yes	s an opsy ormed? 2/4 No	death?	copsy findings available ompletion of cause of
of Vital F Physician: Th	director.	o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatie	ent 3 🗆 D	Other		ath Check onl		6 □Other (Spec	ify)
— 2		h- 1	17 Yes 2 No 27. Manner of Death 1. Matural 5 Pending investig	28a. Date (Mon		28b. Time Injury		28c. Injury at Work?		28d. Describe			,
Division or Attending s after death.	ed in by the funeral	Certification:	3 Suicide 6 Could n 4 Homicide determi	289. Place	of Injury - At h ing, etc. (Speci	ome, farm, s fy)	treet, facto	ry, office			(Street ar own, State		ral Route Number,
Hospitel	completely filled in b	Medical (29a. Certifier 1/2 Certifyin (Check only one) 2 Medical E	Physician: To the Examiner: On the band man	e best of my kn easis of examinationer stated.	owledge, dea ation and/or i	ith occurre nvestigatio	d at the time, da n, in my opinion	te and place , death occi	e, and due to the urred at the time	e cause(s e, date and) and manner as d place, and due	stated. to the cause(s)
To the within 2	ro the	Mec	29b. Signature and title of conflict					c. License num				ite signed (Month	
			MUS	Dr M	0		/	10 6	031	9	06	-21-2	004
L (-	5)		30. Name and address of person	who completed cau		m 23a) (Type	Print)	Adias	hst.	HOSD. 17	Takon 600	-21-E ua Park Carrol	(Aug.
No.	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. 1	Registrar's Sign	ature	1	0 10.000		7			

RPD	74044		1 - State of Maryland / Department	artment of Health and N	, 0	0001	20070
	Physici	ian	Decedent's Name (First, Middle, Last) Vernon Dickerson	imodio of Dodin	2. Date of Death Month	Day Year	3. Time of Death
	/Medie		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June 20	4c. County of Death	0249 A ^M
	Examir	ner	3323 Dallas Drive	Marlow Heights		Prince Ge	orgola
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtho	olace (State or Foreign
	Director		326-48-5181 1⋅2⋅ 50 yrs.	Months Days Hours Min.	March 23	9. Birthp 9. Birthp 9. Birthp	řet, Il
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.				
	show	5				1	0d. Inside City Limits 1 Yes 2 No
	or 28a-f	Director	Md Prince George's Temple F	10f. Zip Code	10	Citizen of Milest Court	
	with					g. Citizen of What Cour	Addition to the second
	items 23a	Funeral	4511 23rd Parkway #103 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20748 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	Inited State	
S	or iter		Armed Forces? If	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
93	ours a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Bla	ack
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. s marked other than "netural", or items 23e or 28e-f show umatic event, the Medical Examt for must be rediffed ut	Completed	(Specify only highest grade completed) (Give :	dent's Usual Occupation kind of work done during most of work	ina 1	6b. Kind of Business/Inc	dustry
21	ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Furniture			
2	lled v lygie her tl		1.7 Father's Name (First, Middle, Last)				· · · · · · · · · · · · · · · · · · ·
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be			e (First, Middle, Ma	alden Sumame)	
Š	d 2 should th and Mer 7 Is marke traumatic	2	Cora B. Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Run	Vasser	City or Tourn State Zin	Codo
Ma	12 h a 7 Is		1111	23rd Parkway #103		, , ,	,
ē	- T & =	1 "	20a Method of Disposition 20b, Place of Dispos	sition (Name of	-	Oc. Location - City or To	
Baltimore,	Pages nent of I int: if its		1 & Burlai 2 Cremation 3 Hemoval from State	natory or other place)	7 2 0/ 12	Traced T1	
Ē	permit. I Departm Importar any injur	1	HD allam I	Lincoln Cemetery 7 2. Name and Address of Facility		tol Mortua:	ry Inc.
ä	Per im per per per per per per per per per per		Maron John - Jally 11	425 Maryland Ave.,	•		
			23a. Part 1. Enter the disease, or complications that caused the death. Do of ente shock, or heart failure. List pny one cause on each line.				Approximate Interval Between
	Pnysician	8 J	Immediate Cause (Final disease or condition	Gunshot Wounds		Į.	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	ounties inouncis			
- 8	Examiner		Sequentially list conditions b.				10
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and -trans	Examiner	that initiated events c.				
8760,	or Attending Physician: The law requires that the death certificate be executed ifter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	E	Due to (or as a consequence of):				
87	physic the	dical	d				
9 X	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			004 Date of deliver	
Вох	atten for u	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ny Day Year
P.O.	t the de by the tached	ıysi	1 Yes 2 No 9 Unknown	g a trait (appearly)		40.00	
	that	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
rds	quires n sign uld be				1 ☐ Yes	2 X No 3□Proba	ably 4 Unknown
00	aw requir 1s been si 2 should	ojet			24a. Was an	24b. Were autor	osy findings available
Re	The la	Completed			autopsy performe 1 Yes 2	prior to con ed? death?	npletion of cause of
Vital Records,	ystcian: The is certificate hidirector, page	a)	25. Was case referred to medical	26. Place of Death	(Check only one)		2 No
	nystci nis cer direc	To B	examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		ce 6 X Other (Specify	At Scene
n of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
sio	ttendin death. stor: Af the fur	cati	2 Accident investigation 6/20/04 2:45 A	1 M 1 □ Yes 2 No	subject u		
Division	l or Atl after d Direct I in by	Certification:	determined determined building, etc. (Specify)		City or Town,		Route Number,
				ricle	3523 Dall		low Heights, nor
	Hos 24 ho Fune fely f	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death (2 ☑ Medical Examiner: On the basis of examination and/or inv and mannerstated.	noccurred at the time, date and place, a restigation, in my opinion, death occurr	and due to the cau ed at the time, date	ise(s) and manner as sta e and place, and due to	ated. the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Med	29b. Signature and title of certifier	29c. License number	29d	d. Date signed (Month, L	Day, Year)
	F ≥ F 8		X / //	O.C.M.E.		une 20, 200	* * * * * * * * * * * * * * * * * * * *
1)	61)		30. Name and address of person who completes cause of death (Item 23a) (Type, F	Print)			
1	4		Whay G. RIPP US M	111 Penn Street,	Baltimo	re, Marylan	d 21201
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
B	Registr	ar	JUN 2 9 2004 Block & Cook	r e			

	1	For State Registrar	ase Type or Pri SperInf . C837 State of M	iai yiai ia i		tificate c			illa ivio	iiiai iij	Rag. No.	004	2238	30
		Decedent's Name (First, Midd	tle, Last)						2	. Date of D	eath	Vone	3. Time of	Death
Physicia /Medica		Gregorio	Amaya Di	laz					J	une	26	2004	11:58	Ам
Examine		a. Facility Name (If not institution Holy Cross H	Mospital			4b. City, Town	er s	Spri	ng		M	County of Deat	ery	
Funeral Director		5. Social Security Number 213-61-5908	6. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. last b	Yrs.	If Under 1 Ye Months Da		f Under 2 Hours	Min. 0	Date of 8 (Month, D	irth Pay, Year) 1961	9. Birt E1 S	hplace (State of buntry) Salvador	r Foreign
w h	-	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, To	wn or Loc	ation							10d. Inside Cit	ty Limits
ied abel	ţō	Maryland Mont	gomery	Ro	ckvi	11 e							1 X]Yes	2 🗌 No
or 28e a noff	Director	10e. Street and Number	8			10f. Zip Cod	е				10g. Citiz	en of What Co	ountry?	
23a		12714 Parklan					2085					Salvado		
2 8	by Fur	11. Marital Status 1 (X) Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	:7		Vas Decedent (Yes, specify C						4. Race - Ame Black, Whit Specify: Whit	e, etc.	
natur	eted	15. Decede (Specify only high	ent's Education est grade completed)	16	a. Deced (Give I	ent's Usual Ockind of work do NOT use re	cupatio	on ring most	of working	7	16b. Kin	d of Business	Industry	
than "	Completed	Elementary/Secondary (0-12)		r 5+)		oo not use re sekeepj					Re	-Kos		
d other	Be	17. Father's Name (First, Middle		· · · · · · · · · · · · · · · · · · ·			18			First, Middl	e, Maiden S Laz	Sumame)		
and Mer Is marke reumatic	P	Agustin Amay 19a. Informant's Name/Relation	nship (Type, Print)	l'i	9b. Mailin 2714	g Address <i>(Ştr</i> Parkla	eet and ind	d Numbe Driv	r or Rural i	Route Num	ber, City or	Town, State, 2	Zip Code)	
Health em 27 ther t	-	Dionicio Amaya 20a. Method of Disposition	Nepnew	20b. Place	of Dispos	ille, Name of	f	yland	1, 20 Da		20c. Loc	ation - City or	Town, State	
r: # it		1 ØBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ceme	tery, crem	netery	place)	C	7-06-	-04			El Sal	vado
artme orten injur) B.	}	21. Signature of Funeral Service			•	•	Idress						ome, Inc	
o d d		Wanda C	Bacon, C	12 36	/ 3	447 14t	h S	St.,	N.W.	Wash	., D.	C. 2001	.0	
ysician Medical caminer stude on and stude on and students of the students of	edicai Examiner	23a. Part1. Enter the disease, a shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. He mo Due to (or a b. A or to Due to (or a	as a consequence tense tense as a consequence tense t	cha of):	m							Onset and E	Death
ed by the attending physici detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal dea at time of death		Ectopic pregna Other (specify					2	3d. Date of del Month		/ear
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cate has been s	Completed									24a. Wa aut per 1 XXes	opsy formed?	24b. Were au prior to death?	utopsy findings a completion of ca 2 \(\sum \) No	available ause of
is certificate director, pag	o Be	25. Was case referred to medic examiner? 1 Yes 2 □ No	Hospital	W FO	:	t 3 DOA	Other:			Check only				
ith. : After this e funeral di	-	27. Manner of Death 1 Natural 5 Pend	28a. Date of Ir (Month, I		D. Time of Injury	28c.	lnjury a Work?	7 110	28		e how injury	Other (Spe	icity)	
after death.	Certification:	3 Suicide 6 Coul 4 Homicide deter	Id not be mined 28e. Place of building,	Injury - At home etc. (Specify)	, farm, str	eet, factory, off	ice		28		(Street and own, State)	Number or Ri	ural Route Numi	ber,
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within 2 To the complete	Me	29b. Signature and title of certif	0 11	is Mo		29c. Lie			M.E.			e 26,		
	1													

4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM VA MARYLAND HEALTH CARE SYSTEM VE MARYLAND HEALTH CARE SYSTEM VE MARYLAND HEALTH CARE SYSTEM PERRY PERRY LIU Index 24 His. a. Date of Birth Country 104. Date of Country 105. Social Security Number 219 42 1523 106. Country of Death Act Country of Death CECIL Country 107. Social Security Number 108. Social Security Number 109. Social Security Number 109. Social Security Number 109. Social Security Number 109. Social Security Number 109. Social Security Number 100. Inside City 101 (2) Code 100. City, Town or Location 101. Income Number 100. Inside City 101 (2) Code 100. City Town or Location 101. Income Number 100. Inside City 101 (2) Code 100. Inside City 101 (2) Code 100. Inside City 101 (2) Code 102 (3) Social Security Number Security Number Security Number Security New Or No. No. No. No. No. No. No. No. No. No.	vsicia	n	Decedent's Name (First, Middle, Las	,				Date of De Month		Year		ne of Dea
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100. State 100. County 1			219 42 1523		V.	Months Days	Hours Min.	(Month, Da	y, Year)	5 Ma		
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Content Cont	Ties.	żo	Maryland Cecil		E1kton						1 🗆	Yes 2
Committee Comm	Tall I	ire	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What (Country?	
Margie Dula (Myers)	TS I	aj	862 East Old Phil	adelphia Ro	ad	21921			Unit	ed Sta	tes	
Column and Same Americal Control (Type, Print) 19th Maling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)	PE-	ner	11. Marital Status	Armed Forces?		 Was Decedent of His If Yes, specify Cuban 	panic Origin? (Spe	ecify Yes or No Rican, etc.)	- 1			ın,
Color Colo	長			1 X Yes 2 ☐ No If Yes, Give	1966-			. ,				P
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Margie Dula (Myers)	ii.				ror			(First, Middle,			Walker	<u> </u>
23a. Part I. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infernal Between Onset and Death Classes (Final disease or conditions, infernal Between Onset and Death Classes (Final disease or conditions, infernal Between Onset and Death Classes (Final disease or conditions, infernal Between Onset and Death Classes (Final disease or conditions, infernal Between Onset and Death Classes (Final disease or conditions, infernal Between Onset and Death Classes (Final disease) (Fi	9 0	8						,		5577127757		
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disease or condition recording in dealth) as the conditions. Sequentially list conditions. If any, leading to immediate cause (Disease or injury resulting in dealth) Last Due to (or as a consequence of): Due			shock, or heart failure. List only of	one cause on each line.		onto the mode of dying,	, 00011 00 0010100 0	n roophatory at	1031		Interval	Between
Due to (or as a consequence of): Due to (or as a consequence of):			disease or condition	a							UNKN	NWC
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 22. 2004 7:40a June Robert Gaskins /Medical Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata Charles If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 09 12 47 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 578-64-4230 56 Director Washington, D.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rai', or itame 23a or 28a-f ehow Examiner must be notified at 10d. Inside City Limits 1X Yes 2 □ No Charles Waldorf Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2915 Mighty Oak Place 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married obert Gaskins Ir-1 ☐ Yes 2 No Specify: Specify:Black þ 3 Widowed 4 Divorced or than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th. Electrician **PEPCO** ies 1 and 2 should be filed of Health and Mental Hygis of Health and Mental Hygis if item 27 is marked other or other traumatic event, iii 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Gaskins, Sr. Bernice Cephas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2915 Mighty Oak Place Waldorf, Md. 20605

Date 20c. Location - City or Town, State Lillie Gaskins/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it eny injury or o ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 6-29-04 Cheltenham, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MArshall's Funeral Home 23a. Park: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final +40 **Physician** dou disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner & Sis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes AZ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home ၉ Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (0-22-200 D-46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Mirza Alikhani, 118 LaGrange Ave., LaPlata, MD 20646 31. Date filed (Month, Day, Year)
JUN 3 0 2004 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

			for State Registrar	State of	Maryland	-	artment <i>tificate</i>			and M	ental Hy	gien	200	Service of the servic	2220	_
			Decedent's Name (First, Middle	e, Last)							2. Date of De	ath	and the	j boja	3. Time of Death	.h
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	/Medio Examir		4a. Facility Name (If not institution	, give street and numb	er)		4b. City, T	own, or	Location of	of Death	ounc		c. County		111.50A	*
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	Funeral		5. Social Security Number		Age (In yrs. la	st birthday)	If Under 1		If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th			lace (State or Fore	eign
ш	Director		579-24-3162	1 ☐ M 2 🔀 F	89	Yrs.	WOTHIS	Days	Hours	WIII I.	Oct. 2	3,19	914	North	Carolina	
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	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow dical Examana the Lodified at	by Funerai Director	1346 Kenyon St	reet, N.W.			200					US US	itizen of W SA	mat Cour	itry?	
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d 2	Hygie Hygie ther	ပိ	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle			e)		
au	ld be i	To Be	William Blount	•							Cannon	, maide	, Jumann	5)		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow or other treumatic event, the Medical Exams are rintal Les routified at	-	19a. Informant's Name/Relations Sheila Bingham/			19b. Mailir 902 Hi	g Address (Street a	nd Numbe	or or Rura	I Route Number	er, City	or Town,	State, Zip	Code)	
	1 an Heal em 2		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name	g of			ate	20c. L	ocation -	City or To	wn State	
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Il Records, P.O. Box 68760,	sicien: The law requires that the death certificate be executed by the attending physician and in property in a certificate has been signed by the attending physician and in procler, page 2 should be detached for use as the burial-transit	Completed by Physiclan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	as a conseque as a conseque as a conseque me of pregnan 2 □ Fetal of at at time of dec	ence of): cy feath 3 ath 5	Ectopic pre	gnancy city)			1 🗆 \	Yes 2	24b. W	bute to th	ry Day Year e cause of death? ably 4 □Unknov osy findings availat npletion of cause o	wn
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ū	fter ne	on:	27. Manner of Death 1 □ Natural 5 □ Pendin		Injury Day Year)	28b. Time of Injury		c. Injury Work?			8d. Describe t	now inju	ry occurre	d		
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Division of	lor Att after d Direct I in by	Certification;	4 Homicide determ	ined 286. Place of	Injury - At hon , etc. <i>(Specify)</i>	ne, farm, stre	eet, factory,	office		2	8f. Location (5 City or Tox	Street ar vn, State	nd Numbe e)	r or Rura	Route Number,	
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2_	(2)		30. Name and address of person Thong Bao, M.D. 13				Print)				e				(
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 20	2. Reg	istrar's Signatu	re		·								

DHMH 17 Rev 1/2001

GALDNER, ELIZASOTH

			For State Registrar	State of Marylan		artment of F		•	giene Reg. No. 2004	22386
Ŷ	Physici	an	Decedent's Neme (First, Middle, Last	•	-			2. Date of Dea Month	Day Yee	3. Time of Death
*	/Medic	al	HAZEL MARIE	GIBSON		4b. City, Town, o	r Lagation of F	June	9 2004 4c. County of De	3100P M
L	Examin	er	4a. Fecility Neme (If not institution, give 3908 D Stonegate			Suit1a		Death	Prince G	
	Funeral		Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, Da)		irthplace (State or Foreign Country)
	Director		239 66 2302	□ M 2 Q F 62	Yrs.	Months Days	Hours	Jan. 26	, 1942 No	rth Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Manyl	tor	Maryland Prince Ge	eorge's Su	itland	,				1 TYes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath will		3908 D Stonegate I				0746		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic avant, the Madical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates:			lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. Black
Ö	2 hou	ted	15. Decedent's Edi	ucation	16a. Dece	dent's Usual Occup	ation	faddia.a	16b. Kind of Busines	s/Industry
2	ithin 7	Completed by	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired		I WOIKING	D=D 40	
7	Hygier Hygier Her th	S	12th 17. Father's Name (First, Middle, Last)		Ra	ite Resea		Name (First, Middle,	PEPCO	
Maryland 21215-0036	id be fental h	To Be	Solomom Rogers					annie Gorh		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Numbe		, Zip Code)
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Baltimore,	ges 1 t of H if Iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	Removal from State	semetery, crei	osition (Name of matory or other place		Date	20c. Location - City of	
Ë	it. Pa irtmen irtant: njury		* 4 □ Donation 5 □ Other (Specify, 21. Signal re of Funeral Service Licens			Cemetery		6-16-2004	Suitland,	
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8760,	Physician /Medical Examiner physician and physician and physician and physician street phys	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conseq b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of):					Interval Between Onset and Death
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	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
	(1)		1 Vau/M			Do	0476	12 MD 20	6/15/	07
12	1201		30. Name and address of person who d	completed cause of death (Item	n 23a) (Type,	Print)	Q h	1 110 00	18 A1	
	Sta	te.	Dr Paul Mac Noul 31. Date filed (Month, Day, Year)	8218 Wisconsi	ature August	JTC. 414	HETW SC	in 190 do	10 14	
13	Regist		JUN 2 8 2004	French . K	boar	6)				

			1- For Amend Item 23a Registrar	per Dr.,G833,0/	/15/0 /ch	tificate of E	ealth and Mental F Death	Reg. No.	nni.	222	07
	Ħ		1. Decedent's Name (First, Middle, Las				2. Date of Month		Year	3. Time of	Death
	Physici /Medio		Thomas N	Norton Given,	Sr.		June	8	2004	1255	P M
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		unty of Death		
			Union Hospital 5. Social Security Number 6. Se	ax 7. Age (In yrs	last hirthday	Elkton If Under 1 Year	If Under 24 Hrs. 8. Date of		cil	Jan (Ctate o	a Camina
	Funeral Director			X M 2□F 86	Yrs.	Months Days		Day, Year)		elece (State ontry) aware	or r-oreign
10	D	ġ.	Usuel Residence of Decedent				oune.	11 121			
	arylar show	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation			1	0d. Inside C	
	death with the Maryland rms 23a or 28a-f show r rount be notified at	Director	Maryland Cecil		Elkton	1.00		1 0!!		1 ☐ Yes	2×100
	with t	D	10e. Street and Number			10f. Zip Code			of What Cour		
	ns 23	Funeral	20 Montrose Lane	12. Was Decedent Ever in U	J.S. 13.	21921 Was Decedent of His	panic Origin? (Specify Yes or		ted St		
	r iter		1 Never Married 2 Marned	12. Was Decedent Ever in I Armed Forces? WOY 1 XYes 2 No Wa If Yes, Give	30		spanic Origin? (Specify Yes or , Mexican, Puerto Rican, etc.)		Black, White,		
ğ	72 hours after natural; or ite	l by	3 X Widowed 4 ☐ Divorced	Year or Dates:		1 □ Yes 2 🂢 No	Specify:	Sp	ec <i>ify:</i> Wh	nite	
5-	72 h natu	etec	15, Decedent's Ed (Specify only highest grad		16a. Dece (Give	dent's Usual Occupation of work done di	tion uring most of working	16b. Kind	of Business/In	dustry	
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>bo not use retirea)</i> hanic		Pnai	no Don	0110	
g 0	filed Hygi other		17. Father's Name (First, Middle, Last)		nec		18. Mother's Name (First, Mide		ne Rep	all	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event. Ine M	To Be	Walter C. Given				Marguerite Mc	Nabb			
ary	should and Men s marke		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rural Route Nui		wn, State, Zip	Code)	
Ž	1 and 2 Health a tem 27 is		Charles E. Given,				Road, Newark,	Delawar	e 1971	3	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat; or items 23a or 28a-1 show any injury or other traumatic event. It is Wedical Examiner man be notified at ODGs.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	1	Place of Dispo cemetery, crer	sition (Name of natory or other place	June 12,	20c. Locati	on - City or To	wn, State	
Ë	Pag Iment tant: jury c		*4 □ Donation 5 □ Other (Specify			emetery	2004	Union	, Mary	land	
Ball	Depar Impor any in		21. Signature of Funeral Service Acen		H H	Name and Address	for Funerals, ckton Street,	P.A.			
			23a Part I Enter the disease or comm	alignations that caused the dea	th. Do not ent	03 W. Sto	ckton Street,	Elkton,	Maryl:	and 21 Approximat	
		0. 0	23a. Part 1. Enter the disease, or come shock, or beart failure. List only Immediate Cause (Final	ne cause on each line.	spiratio	g Preuronia	1. or	allest,		Interval Bet Onset and I	ween
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	SONA	dy Dis	MESS			9 990	10
N	Examiner	li		Commende	in w	PD			- 4	1	40
65	- * ·	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quance of).					_	7
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dilai						000	45
8760,	De execien a		resulting in death) Last	Due to (or as a conse	quence of):					٧ .	200
387	physicate I	dice		d.				-		196	614
Box 6	The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy		23d.	Date of delive	•	ear ear
P.O.	the a	ysic	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)		-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	July	02.
œ.	that the by detact	/ Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause giver	n in Part I. 23e. Di	d tobacco use o	contribute to th	e cause of d	eath?
ds	uires n sign lid be	d b	Dementa, Cono	gested Har	+ Fa	ilur.	CUA, 11	JYes 2∭ N	o 3 Prob	ably 4 🗀 L	Inknown
000	s beer	Completed by	Tickenic Can	Liomunoati	60	,	24a. W	asan 24	b. Were autor	osy findings a	available
Re	The la	E O	9,10,77,70 00,70	ren igapoint	7		pe	topsy rformed?	prior to con death?	npletion of ca 2□ No	ause of
	sicien: The law certificate has E irector, page 2 s	Bec	25. Was case referred to medical				1 ☐ Yes 26. Place of Death (Check onl		1 1 1 1 1 1 1 1 1	2 140	
	s ce	To	examiner?	Hospital: W.] ER/Outpatier	Other				<i>(</i>)	
1	£ 2	\vdash	1 193 500 110	1 X Inpatient 2	2 Li v O O (patio)	t 3 DOA	4 Nursing Home 5 Re	sidence 6 🗆	Other (Specify	/	
on of Vital Records,	ing Phys After this uneral dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at 28d. Describ	e how injury oc		/	
ision of V	ttending Phy death. stor: After this		27. Manner of Death 1. Natural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury: Work? M 1 7	at 28d. Describ	e how injury oc	curred		hor
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Division	5+1	a Medical Certification;	27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 1 Certifying Phyone) 29a. Certifier Certifying Phyone 2 Medical Example 29b. Signature and title of certifier 30. Name and address of person who call the performance 1 Certifying Phyone 30. Name and address of person who call the performance 1 Certifying Phyone 2 Medical Example 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the performance 2 Certifying Phyone 30. Name and address of person who call the person who call the performance 2 Certifying Phyone 30. Name and address of person who call the person who call the person who call the person 30. Name and address of person who call the person who call the person 30. Name and address of person who call the person who call the person who call the person 30. Name and address of person who call the person who call the person 30. Name and address of person who call the person	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I building, etc. (Specials on the basis of examinand manner stated.	28b. Time of Injury nome, farm, str nowledge, death ation and/or inf m 23a) (Type,	28c. Injury Work? M 1 TY eet, factory, office	at 28d. Describes 2 No 28f. Location City or 3e, date and place, and due to the nion, death occurred at the time.	n (Street and Nurown, State) ne cause(s) and e, date and place	umber or Rura manner as st ce, and due to	Route Numi	

		•	1 - For State Registrar	State of Marylan			it of He e of D		, ,	giene Reg. No.2	004	22388
	Physici		1. Decedent's Name (First, Middle, Last)	Kisha Patr	ice H	all			2. Date of Dea June 29		4 Year	3. Time of Death 9:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give si Ft. Washington Ho					ocation of Dea			unty of Death	eorge's
	Funeral		Social Security Number 6. Sex				r 1 Year	If Under 24 Hr Hours Mir	s. 8. Date of Birt	h	9. Birthp	place (State or Foreign
v) M	Director		Usuel Residence of Decedent						pan II,	19/1		ington DC
	Marylar fed at	tor	10a. State 10b. County Maryland Prince	George's	y, Town or Lo П		e Hil	ls				10d. Inside City Limits 1
	or 28a-	Director	10e. Street and Number				Code			10g. Citizer	of What Cou	ntry?
	eath w		4002 19th Avenue	2. Was Decedent Ever in U	S. 13.	Was Dece	2074		Specify Yes or No-	14.	USA Race - Americ	can Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23e or 28a-f show spiritury or other traumatic event, Ite Marical Exameter must be notified at once.	by Funeral	1 Name States 1 Name States 1 Name States 2 Married 3 Nidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	lf Yes, spe 1 ☐ Yes	cify Cuban,	Mexican, Pue Specify:	rto Rican, etc.)		Black, White,	
21215-003	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	kind of wo	al Occupations dur	on ring most of w	orking	16b. Kind	of Business/In	dustry
2121	yene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	iire. i		se retired) Iomema	ker			Priva-	te
	Mental Hygid Mental Hygid arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Nello Hall				1		eme (First, Middle, 5 Reva Wi			
Ž	and 2 should lealth and Men m 27 is marke her traumatic	-	19a. Informant's Name/Relationship (Type Iris Reva Hall (M	oe, Print) Other)					Aural Route Number			Code)
Baltimore,	Pages 1 are nent of Hearn of Hearn of Item Int. If item Iry or other		20a. Method of Disposition 1 🗆 Burial 2 🖾 Cremation 3 🗆 Re	emoval from State	lace of Dispo emetery, crer	matory or	other place)		Date		ion - City or To	
Ē	permit. Page Department i Important: If eny injury o		* 4 □Donation 5 □Other (Specify) 21. Signatur of Funeral Service License		esapeal 22	-			2/2004 endon/Hal		sville eral Ho	
 	Dep den yen		Man 9	en_					ad, Lanha			ALC.
	Physician	/	23a. P. m1. Enter the disease, or complice shock, or heart failure. List only on the mediate Cause (Final disease or conditions)	cations that caused the deat e cause on each line.		ter the mod		such as cardi	ac or respiratory an	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	D	11	· 10				· · · · · · · · · · · · · · · · · · ·
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	and and II-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	<u> </u>	TER	EHIA				
8760,	cate be executed physician and the burial-transit	dlcal E	L _d	STAGE 1	<u>. v S</u>	S AER	A	Dece	igi bus			
39 X	certifica nding ph	/Med	IF FEMALE: 23	3c. If yes, outcome of pregna	incy					23d	Date of delive	anv
.O. Box	that the death certifi led by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		□Ectopic p □ Other (s)				200	Month	Day Year
ds, P.	Se Dec	þ	Part II. Other significent conditions con	tributing to death but not res	ulting in the u	nderlying (ause given	in Part I.		bacco use		ne cause of death?
Vital Records,	law requin as been si 2 should t	Completed							24a. Was a			psy findings available mpletion of cause of
	ilcian: The lar certificate has rector, page 2				, <u>-</u> .				perfor		death?	
	Physician: r this certificanal director,	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatier	nt 3[] D	Other		eath (Check only of Home 5 - Resid		Other (Specifi	iv)
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Division of	l or Attending after death. Director: Afte in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, larm, str	M reet, factor		s 2∐No	28I. Location (S City or Tow	treet and N	u <i>mber</i> or Rura	il Route Number,
۵	Fq the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by											
	Fo the Hospital within 24 hours and To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wiedge, deat! tion and/or in	h occurred vestigation	at the time, i, in my opin	ion, death occ	e, and due to the curred at the time, o	ause(s) and date and pla	d manner as si ce, and due to	ated. the cause(s)
	within To th	Me	29b. Signature and title of certifier	VOS	MI	29	c. License n	number	12	29d. Date si	gned (Month,	Day, Year)
	1/p		30. Name and address of person who/co	mpleted cause of death (Item	n 23a) (Type.	Print)	200	الم كا	50	6/2	4104	,
	SH		Samuel J. Kleim	an, M.D. 11	711 Li		ton R	oad, F	t. Washin	gton .	MD 2074	14
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa								

B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. DALE ALLEN HAWKINS KINS
State of Maryland / Department of Health and Mental Hygiene
T-State State of Maryland / Department of Health and Mental Hygiene
Reg. Mo.
Reg. Mo.
Reg. Mo. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2004 **Physician** 2, JULY Dale 0942 A^{M} Hawkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9401 LARGO DRIVE WEST ROOM 327 LARGO PRINCE GEORGES 8. Date of Birth Jan. 8, 1980 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. West Virginia Months Days Hours 1 XM 2 ☐ F 24 235-17-8722 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 ahow traumatic avant, the Medical Examiner must be notified at Ind. Tippecanoe Yes 2 □ No Director Lafayette 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 1433- Columbia Street Items 23e 47901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. In and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Hawkins Della L. McKinney 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health and Important: If itam 27 is r any injury or other traur 9341-W.County Line Rd., #6505-Colfax Ind. Della Hawkins- Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Tippecanoe Mem. Gardens-7/8/04-W. Lafayette, Ind. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service II Hysong Co.-6510--16th St., NW son wash., DC 20012

caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of) Examine certificate be executed use as the burial-transit Cause (Dissass or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by eq 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 No 2 No Division of Vital Yes : After this certifica e funeral director, r or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6XX ther (Specify) 1

Yes 2□ No 2 AT SCENE 28a. Date of Injury Found Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Found: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2**X**☐ No 2 Accident Unknown 7-2-04 Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number of Rural Route Number, City of Town, State) Found: 9401 Largo Dr 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funaral Dirac completely filled in by 4 Homicide West Largo, MD Found:motel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29o. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E JULY 3, 2004 will Monte

State Registra

111 Penn Street, Baltimore, Maryland 21201 MARYDONTS 以のでして

31. Date filed (Month, Day,) Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of Maryla	nd / Depa	rtment o	of Health and Moof Death	lental Hyg	•	0000		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death		
	/Medi			HUGHLEY				June 21	,2004	11:23 AM		
	Examir	ner	4a. Facility Name (If not institution, give stre Southern Maryland F			Clint	wn, or Location of Death On		4c. County of Death Prince George's			
	Funeral Director			7. Age (In yrs	. last birthday) Yrs.	If Under 1 Y Months D	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, March 8	Year) 9. I	Birthplace (State or Foreign Country) 1abama		
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	cation				10d. Inside City Limits		
	Mary a-f sh	tor	MD Prince Geor	ge's Cli	nton					1 ∏Yes 2 □ No		
	death with the Maryland ms 23a or 28a-f show	al Direc	10e. Street and Number 9211 Stuart Lame			10f. Zip Co 2073		10	og. Citizen of What USA	Country?		
386	ē 2 2	Be Completed by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☒ No lf Yes, Give Year or Dates:		Vas Decedent Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: B.			
クゲ // える Maryland 21215-0036	within 72 hours after ane. than "natural", or Ite he Medical Examina	npleted	15. Decedent's Educati (Specify only highest grade or Elementary/Secondary (0-12)	on ompleted) College (1-4or 5+)	16a. Deced (Give i	ent's Usual O kind of work o OO NOT use r	occupation fone during most of work etired)	ing	16b. Kind of Busine	ss/Industry		
2	dygier thar th	Cor	17. Father's Name (First, Middle, Last)		Nurs	ing	18. Mother's Name	o /First Middle A		Industry		
and	d be f antal b ced of	To Be	Unknown				Dorothy		,			
ary C	should and Men	F	19a. Informant's Name/Relationship (Type,				treet and Number or Run	al Route Number,	City or Town, State			
~	and 2 ealth a n 27 ls		VAlerie Bailey/daug				ey Road, Te					
3 - 2/- Baltimore,	Pages 1 ment of H tant: If Ital		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State 20b.	Place of Dispos cemetery, creme etropolita	atory or other	r place) atory 6/28/2	2004 1	20c. Location - City Alexandria,	VA		
6 -	permit Depart Import any in		21 Signature of Funeral Service Limsee	'L_	41	11 Penn	address of Facility (ed Sylvania Ave.,	Suitland,	MD 20746	Inc.		
	Physician		23 Jan1. Enter the disease, or complicate shock, or heart failure. List only one climmediate Cause (Final disease or condition	ions that caused the deal cause on each line. $SePii^{3}$	ith. Do not ente	er the mode of	f dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		- 1 100					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conse	quence of):							
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
60,	te be executed ysician and ie burial-transii	ical Ex	resulting in death) cast	Due to (or as a conse	quence of):							
687	ficate g phys		d									
P.O. Box 68760,	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al déath 3□	Ectopic pregn Other (specif			23d. Date of o	delivery Day Year		
2	± 96 €	by	Part II. Other significant conditions contrib	outing to death but not re	sulting in the un	derlying caus	e given in Part I.			to the cause of death? Probably 4 Unknown		
, Doroth	iician: The faw require certilicate has been si rector, page 2 should t	Completed						24a. Was an autopsy perform 1 \(\text{Yes} \) 2	prior t			
Ital	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?				26. Place of Death					
2,20	Physic this or	은	1 ☐ Yes 2 ☑ No Hosp	1 inpatient 2	ER/Outpatient				nce 6 Other (Sp	pecify)		
on on	ding Ih. Th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28C.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred			
Ugh/ey Division of	af or Attan s after deal I Diractor. Id in by the	Certification:	3 Cuisido 6 Could not be	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, of	fice	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,		
7	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	an: To the best of my kn On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the	he time, date and place, my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)		
	To the within comp	Σ	29b. Signature and title of certifier	1 100		29c. Li	cense number	29	d. Date signed (Mo			
	$\overline{(a)}$		Roisten Farain				Duzune		6.22.0	4		
CF	-(2)		30. Name and address of person who comp RocrFAN FARAH() 31. Date filed (Month, Day, Year)	FAR MO	7801 0		Ave suit =	3-41 5.10	m spring.	My 20902		
	Sta Registr		JUN 3 0 2004	Registrar's Sign	Apan	W						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** HARVEY ETHEL G. June 24, 2004 2:15am /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner Prince Georges Hyattsville
Under 1 Year | If Under 24 Hrs. Sacred Heart Nursing Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Yeer) **Funeral** Days Hours 1 ☐ M 2 🖺 F Min. Yrs 94 Director 577-50-3166 October19,1909 WDC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other then "naturel", or items 23a or 28a-f show traumatic event, the Medical Examents found be notified at 1 Yes 2 □ No Hyattsville Prince Georges Md. Direct 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code 20782 5805 Oueens Chapel Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1

✓ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Statistical Clerk Government 3 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be is marked o Pearl Smith Harry Harvey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1900 Chapman Rd. Hyattsville, Md. 20783 Janice Glover/friend Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
eny injury or ot Lincoln Memorial Cemetery 6/29/04 Suitland, Md. 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy St., N.W. Washington DC 20011 Approximate Interval Between Onset and Death Part 1. Enter the disease, or compileations that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final da **Physician** 89 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death Month Day detached for 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24e. Was an autopsy performed? Yes 2 No has page 2 certificate 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Quirsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 3 DOA 1 Inpatient 2 ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Rd., Ste. 202 Gaithersburg Md. 20878 Raman R. Tuli, M.D. 31. Date filed (Month, Day, Year)
JUN 2 9 2004 32. Registrar's Signature State Registrar

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			1 - State Registrar		, , , , , , , , , , , , , , , , , , , ,		tificate of l			g. No. 2 0 0 4	22392
	Physici	an	1. Decedent's Name (First, Middle, La	st)					Date of Death Month	Day Yea	3. Time of Death
	/Medic	al		comb			4h City Town or	Location of Death	June 2	4c. County of D	9:35 a.m. ^M
	Examin	er	4a. Facility Name (If not institution, giver Calvert Memoria					Frederi	o k		lvert
	Funeral		5. Social Security Number 6. S	ex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		220-34-4612	M 2□ F	90	Yrs.	- Days	110010	Dec. 4,		ennessee
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation			_	10d. Inside City Limits
	a-f sh	tor	Maryland St. M	lary's			Califo	ornia			1 ☐ Yes 2 🖪 No
	or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
	s 23a		44036 Fieldston		edent Ever in U.	C 13 V		0619		Jnited St	ates merican Indian,
(0	r Hem	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Fe	orces? 2 □ No 193	4-		ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.
036	ours a	1 by	3 Widowed 4 Divorced	If Yes, G Year or D	V9 105	5	☐ Yes 2 No			Specify:	White
5-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Exaculties is ust be notified at once.	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	lent's Usual Occupa kind of work done of	ation during most of work f)	ing	6b. Kind of Busine	ss/Industry
12	withir ene. than	duo	Elementary/Secondary (0-12)	College (1-4or 5+)			v Loned Off		U.S. N	lavv
Jd 2	filed If Hygi other	Be C	17. Father's Name (First, Middle, Last,)					e (First, Middle, M.		<u></u>
/lar	Menta Menta arked	ToE	Pulaski Holcomb					Nel1	ie Moses		
Aan	2 sho and ts m		19a. Informant's Name/Relationship (and Number or Rur		•	
e e	1 and Health em 27 ither t		Nellie Lee Holc 20a Method of Disposition	omb / W	Vife 20b. P		Fields to sition (Name of natory or other place			ia, Maryl Oc. Location - City	and 20619 or Town, State
nor	ages ent of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 🛣		STATE			Cem. 7-3			
altir	nit. Poartme		21. Signature of Funeral Service		Ele						Home, P.A.
ä	permi Depa Impo		David A. Goff	CHOT	MO 10	95 22	955 Holly	wood Roa	d, Leonar	dtown, M	D 20650-0279
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	oligations that	caused the death	h. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Irnmediate Cause (Final disease or condition resulting in death)	a Me	Tasta	1	1 . 1 . 1	des	Cance		Offiser and Death
	/Medical Examiner		resulting an dealth)	Due to	(or as a conseq	uence of):					
		ler	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):					
	cuted nd ransit	Examiner	that initiated events	c							
760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to	(or as a consequ	uence of):					
687		dlcal		_ d							Ya?
Box (n certif anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnancy			23d. Date of c	telivery
. B	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)			Month	Day Year
0.	that the de ned by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions of	contributing to c	leath but not resi	utting in the ur	nderMing cause give	en in Part I	23e. Did toba	cco use contribute	to the cause of death?
S, sp	w requires that been signed should be del	d by	Huperasmolar	- No	n-Ket	stic	State	or in real to			Probably 4. Unknown
(LA)	law requas been 2 should	olete	UTI - Usin	am	taact	i v	rfechi	} ~	24a. Was an	24b. Were	autopsy findings available o completion of cause of
Z e	iician: The lav certificate has rector, page 2	Completed	Diabetes	MeWit	īvs.		V		autopsy performe 1 ☐ Yes 2	ed? death	o completion of cause of ? es 2 \(\subseteq \text{No} \)
√. Vita	cian: ertifici	Be (25. Was case referred to medical examiner?	11			0.1		h (Check only one)		
0 0	Physi this o	<u>۲:</u>	1 Yes 2 No			ER/Outpatien 28b. Time of	28c. Injury	4 Little on g 110	me 5 Residen 28d. Describe how		pecify)
, E	iding Phys Ih. : After this funeral di	tlon	1 ■Natural 5 ■ Pending 2 ■ Accident investigatio		of Injury oth, Day Year)	Injury	Work	√? Yes 2 □ No	20d. Describe now	mjury occurred	
Division	Atter ector by the	Certification:	3 Suicide 6 Could not b	200. Flac	e of Injury - At ho ling, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or . State)	Rural Route Number,
Ō	ital or irs afte ral Dir led in	Cert	O WE								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	miner: On the t	e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
_	o the	Med	29b. Signature and title of certifier	1	inor states.		29c. License	number	290	d. Date signed (Mo	nth, Day, Year)
	40		many s	fu	MD		Do.	59409		06.28	04
	416		30. Name and advess of person who	11 11	. 11	n 23a) (Type,	Drint)	vite 30	D	06.28	desce MI
_			31. Date filed (Month, Day Year)	110	Registrar's Signa	ture &	ad S	vile 30	is ta	mce ire	Sunck In
	Sta Registi		JUN'S	0 2004	Milenen)	A. A.					

			For State Registrar	State of Mar	•	artmen rtificat			and Me		gienę. Rog. No.:		223	393
			Decedent's Name (First, Middle, La	st)					2	2. Date of Dea	ath		3. Time	of Death
	Physici /Medio			John Deale	Hall,	Sr.				June	23,		9:40	P. ^M
1	Examin		4a. Fecility Name (If not institution, giv				Town, or	Location o	f Death		4c. (County of Dea	ith	
В		М.	Heritage Harbo					olis	- 1 1 A			nne A	rundel	-
	Funeral		5. Social Security Number 6. 5	DEN OFF	In yrs. last birthday,	Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da	v. Year)	- C	thplace (State ountry)	
	Director		090-14-5518 Usual Residence of Decedent	8	9 Yrs.				5	Sept.	12,	1914	Maryla	ına
	land w	1	10a. State 10b. County	1	0c. City, Town or L	ocation							10d. Inside	City Limits
	Mary -1 sh	ţ	Md. Anne An	rundel	Annap	olis							1 ∑ Ye	s 2 No
	r 28e	irec	10e. Street and Number			10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	d within 72 hours after death with the Maryland liene. r than "netural", or Items 23a or 28e-1 show the Medical Ezaminer must be notified at	Funeral Director	924 Shipmaste	r Court			21	1401			USA			
7	ems ems	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Deced	dent of His	spanic Orig	jin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)	1	4. Race - Am-		
36	or it		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☐ No	erchant							Specify: Wh		
21215-0036	hours tural	d by	3 ☐ Widowed 4 ☐ Divorced	M:		dent's Usua					16h Kin	d of Business	/Industry	
7		lete	(Specify only highest gra	ade completed)	(Give	kind of wo	rk done di se retired)	uring most	of working	7	TOD. IVIII	d of business	viridustry	
12	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cou	rt c	lerk				Sta	ate of	Md.	
ק	e filec othe ont,	Be C	17. Father's Name (First, Middle, Last							First, Middle,	_	Sumame)		
<u>a</u>	0 to 0	To B	F	Albert Rob	ert Hal	1			Adel	a Dea	le			
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (**								Town, State,		
	and Sauth n 27 ior tra		Estelle G. Ha		Commence of the commence of th	or Colombia and Company							Md. 2	1401
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre				$06-2^{\circ}$			ation - City or		
Ë	Pages Iment of I tent: If its jury or o		`4 Donation 5 Other (Special	ý)	Davidsor									Md.
Baltimore,	permit. Page Department of Importent: If sny injury or gnce.		21. Signature of Funeral Service Lipe	700	all (N.W.	. Cra	ain 1	П∦У.,	Bow	al Ho	me d. 20	715
3			23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final										Approxima Interval Be Onset and	Death
	Physician /Medical		disease or condition resulting in death)	a. Chronic Due to (or as a c		ctive	pu.	TMOU	ary o	aisea	se		year	5
6	Examiner		ADVICTOR DE LA COMPTENZA	Emphyse									year	s
2		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c										
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Degener	ative an	thri	tis						year	S
o,	le be executed ysician and le burial-transit	Exa	resulting in death) Last	Due to (or as a c										
8760,		ical		Dementi:	a								year	S
9	artifica ing ph a as t	Med	IF FEMALE:											
Вох	death certificat e attending phy d for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 (Fetal death 3	Ectopic pr					2:	3d. Date of de Month		Year
0	0 0 2	/sic	1 Yes 2 No	4□Pregnant at tin 9□Unknown	ne of death 5L	Other (sp	ecify)							
۵.	requires that the de neen signed by the a hould be detached f	Ph	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of	death?
ds,	Se 75 ee	d by		•	•	, ,				1 🗆 Y	es 2🎗	No 3⊟Pi	robably 4	Unknown
Record	> 1 0	Completed								24a. Was	20	24h Were au	utopsy findings	available
Rec	e la has	E D								autop perfor	med?	prior to death?	completion of	
Vital	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					OF Place	of Doath (1 Tes Check only or		1 🗆 Yes	2 □ No	
>		To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DC	Othe	r				☐Other (Spe	cify)	
o			27. Manner of Death	28a. Date of Injury (Month, Day Y			8c. Injury Work			d. Describe h				
Division	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigatio	n	oai) injury	М		es 2 🗆 N	40					
Vis	i or Atten after deati Director: In by the	tific	3 Suicide 6 Could not b		- At home, farm, st Specify)	reet, factory	, office		28	f. Location (S City or Tow		Number or Ri	ural Route Nur	nber,
	ital or irs afte ral Dir	Certification;	_											
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Example 1	nysician: To the best of r	ramination and/or in	h occurred vestigation	at the time , in my opi	e, date and inion, deat	d place, and h occurred	d due to the o	ause(s) a late and p	ind manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner states	11-	290	. License	number			29d. Date	signed (Mont	h, Day, Year)	
	To To Con		· Am k		-MD			0519)			e 25,		
Λ	(8)		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	Print)								
	0		Mirza Nussare	e MD, 166	7 Croft	on Ce	entr	e, C	roft	on, Mo	d. 2	1114		
	Sta Registr	_	JUN 2 8 200	2. Registrar's	Signature	de								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day 2004 **Physician** 9, Helen Louise Horman 6:50pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vindobona Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 9, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗷 F 76 Yrs. 212-24-7165 Maryland Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov treumatic event, the Medical Examinar must be notified at Frederick Middletown Maryland 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 112 Locust Court 21769 U.S.A. Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or iten any injury or other treumetic event, the Modifuel Examina Black, White, etc. 1 ☐ Yes 2(TXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otis Cleveland Waskey, Sr Sophia Cross Lavenia ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George W. Horman/Husband 112 Locust Court, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery Jul 13, 2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Jefferson, Maryland 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Ocensee 106 East Church St, Frederick, Maryland 21701 M00706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician multiple myeloma months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA s after dea. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kathleen W Stern No D32073 July 12th, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen W. Stern, M.D., 810 Ninth Avenue, Brunswick, Maryland 21716 31. Date filed (Month, Day, Year) State JUL 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sharifally Isahak June 305PM 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Peath University of Maryland NA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 2 / 3 1 / 5 2 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 → M 2 □ F Months 51 Director 074-54-6406 Guyana Usual Residence of Decedent with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the roust be notified at Director Md. Prince Georges 1X Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8710 Ross St. 20720 U.S.A. death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. r than "natural", or Items permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite Important: or other traumatic event, tre Medical Exandration 1 Never Married 2 X Married ☐ Yes 2 🕅 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 unemployed none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mohammed Isahak Hanifan Isahak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bephia Isahak/ wife 8710 Ross St. Bowie, Md. 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Washington National 7/1/04 Suitland, Md. of Funeral Servic Cense 21. Signi Universal Mortuary 22. Name and Address of Facility 064 411 Kennedy St., N.W. Wash. D.C. 20011 23a. Pan1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician days Maltiorgan dystanction syndrome /Medical Due to (or as a consequence of) Examiner Abdominal sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit schemic colitis Due to (or as a consequence of): attending physician Records, P.O. Box 68760 sepsis Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mmunosuppression Completed 1 Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown trausplant 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) within 2. ÷ 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) T14551 30. Name and address of person who commeted cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, MD 2/201 32. Registrar's Signature State Registrar

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Ī	Funeral Director		5. Social Security Number 6. S 262-03-3142		nge (In yrs. Ia 91		If Under 1 Months	Year If Under a Days Hours	24 Hrs. Min.	8. Date of Birth Month, Day	1912	9. Birthp Court	lace (State or Foreign stry)
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	6		30. Name and address of person who	completed cause of	death (Item :		Print)	ES ST	-)	BALTIME	TVLY 09	MN	21204
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	ire	,,,,,,,	Part I		1- 74		/	
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	₀Funeral Director		5. Social Security Number 2 1 7 - 3 2 - 0 0	10	7. A □M 2XIF	ge (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days		July	irth la <i>y, Year)</i> 2 , 1925	9. Birthp Coun MAR	place (State or Foreign ntry) Y L A N D
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21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show saft jnjury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 3 ☑ Widowed 4 ☐		12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		Yes, specify Cu	Hispanic Origin? (Sban, Mexican, Puer Specify:	to Rican, etc.)	Bla Specia	ck, White,	etc.
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Ma	2 to 2 a		Phyllis M. Nichol								Forestv			20747
re,	s 1 and it Health Item 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	ne of			ate		ation - City or	Town, Stete
Ē	Pages ment of ant: If It ury or o		1 N Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		A I		Memori			7/1/	/2004	La	andovei	c, MD
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens	1000 A	O TIT	22	2. Name an			Ste	ewart F N.E. W			
: 特			23a. Part1. Inter the disease, or compleshock of heart failure. List only or	ications that caus	ed the death.	Do not ent							, DO 20	Approximate Interval Between
	Physician		Immediate (a rse (Final disease or c ** ition	/)	Tun	(ar	vdi	ail	to	Ja	vo the			Onser and Death
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•	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	is a consequer	nce of):								
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Вох	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 □ Live birth	ne of pregnanc 2 Fetal de		Ectopic pri	egnancy				23	3d. Date of de Month	livery Day Year
	ne dea the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of deat	th 5 [Other (sp	ecify)					NOTE:	Suy 1 su
P.0	that the dended by the a		Part II. Other significant conditions co	ntributing to death	but not resulti	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute t	o the cause of death?
of Vital Records,	uires signe ld be	d by									101	res 2 🗆	No 3□P	robably 4 Hunknown
COL	w requ	Completed									24a. Was		24b. Were a	utopsy findings available
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ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
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	ling P	lon:	27. Manner of Death 1 XNatural 5 Pending	28a. Date of in (Month, L	gury Year) 2	8b. Time o Injury	f 2 M	8c. Injury Work	at :? ∕es 2 🔲		8d. Describe I	now injury	occurred	
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	(3)		30. Name and address of person who co								1 1 .	3.m	20770	
		6	Surinder Si				nover	rar	kway,	Gree	enbelt,	TID	20770	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 2004	-	strar's Signatur	-	1.0							
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	_	For State Registrar		State of M	larylan	-	artmen rtificate			and M	ental Hy	Rag. N			22399
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Examine	200	4a. Facility Name (If not institution			7)		4b. City,	Town, or	Location of	of Death		4	c. County of	Death	
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Funeral Director		5. Social Security Number 579-01-7086 Usual Residence of Decedent	6. Sex 1 ☐ M	7. A	ige (In yrs. 87	ast birthday) Yrs.	If Under Months	Days	If Under	Min.	8. Date of Bi (Month, Da May 3	ay, Year	17		elace (State or Foreigr htry) htucky
with the Maryland a or 28a-f ehow Le natified	jo	10a. State 10b. Count Maryland Balti	-	City		y, Town or Lo								1	0d. Inside City Limits 1X Yes 2 □ No
28a-	Director	10e. Street and Number	more	CILY	Da	LLCTINO	10f. Zip	Code				10g. C	itizen of Wha	at Cour	ıtry?
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permit. Pages 1 ar Department of Hea mportent: If item sny injury or other 2008.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation		noval from Stat	e c	emetery, cre-	matory or o	ther plac						-	
it. Pa rtmen rtent: njury		* 4 □ Donation 5 □ Other of 21. Signature of Funeral Service			Met	ropol	Ltan (2. Name an								Virginia
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Physician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complica st only one	cause on each	ed the deat line.	1	1	ne of dyin	1	cardiac c	or respiratory a	arrest,			Approximate Interval Between Onset and Death
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icien: Th certificate rector, pag		25. Was case referred to media	cal						26. Place	e of Death	1 Yes		10 1 -	1105	2 No
ysicien: The is certificate his director, page	To Be	examiner? 1 ☐ Yes 2 🔀 No		spital:	itient 2	ER/Outpatie	nt 3 🗆 D0	Oth			me 5X Res		6 ☐Other	(Specit	y)
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	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be rmined	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, st	reet, factor	y, office			28f. Location City or To			or Rura	i Route Number,
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To the within 2 To the comple	Me	29b. Signature and tille of certi	fier				29	c. Licens	e number	_			ate signed (
		30 Name, and address of parson	D, D	pleto cause o	O death (Iter	п 23a) (Type		33		7			ne 25,		
10		30 Same and address of the Same and Sam	KU L) 3	730 strar's Signa	FAL	157	RD	Bn	UTT	MORE	0)/	MD	2	121/
Sta Registra			2004	Electro	, K	100	W								

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Johnson 0412 June 24, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cheverly Prince Georges Prince Georges Hospital Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** Days Hours XXM 2□F Months 25 November 1,1978 Washington DC 579-02-1573 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examiner is ust be notified at L∏Yes 2∏No Maryland Prince George Directo Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2504 Darel Drive #204 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1¥ Never Married 2 ☐ Married 1 Yes 2000 Specify: Specify: Black If Yes, Give Year or Dates: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Twelth Plumber | Pierce Plumbing Union other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 900g. Leon Johnson Sr Karen Plummer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2504 Darel Drive #204, Suitland MD 20746 Karen Johnson/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National July 1,2004 Suitland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert G. Mason Funeral Home 21. Signature of Funeral Service Licens 1661 Good Hope Rd SE, Washington DC 20020 mes 23. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SHARD FORCE INTRIES a. HULTIPLE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed the burial-tran the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Yes 2 □ No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death or Attending 5 Pending investigation 1 Natural SIBTELT WAS STABBEDD 1 ☐ Yes 2 KNo death. 6/24/04 3:27 A after death Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 4445 BENNINGRO, WASHINGTON OC RESTAURANT 24 hours a Funeral I Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME June 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, MD

111 Penn Street, Baltimore, Maryland 2120

State

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

JUN 2 8 2004

32. Registrar's Signature Bearin N. Sparle

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Robert Lee Jameson **Physician** 2117 p^M June 23, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Laurel Regional Hospital Laurel Prince Georges 8. Date of Birth Month, Day Year 938 Wash. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**⊠** M 2□ F 577-50-1675 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Anne Arundel Laurel Md. Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 20724 USA 14 N. Carol Street deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ZYes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Fence company Machine operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Katherine Jameson Lloyd Jameson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 6785, Columbia, Maryland 21045 Patrick Jameson - Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 06 - 29 - 0420c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page
Department of
Important: If
any injury or
once. Cheltenham, Md. Md. Veterans Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final Allenoscleration ardiovascular **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medlcal use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No autopsy performed? Yes 2□ No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XDOA ٩ 1XYes 2 □ No ö After thi funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 | Homicide e Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month. Day, Year) June 24, 2004 29c. License number 29b. Signature and title OCME mplete cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 30. Name and address of person

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUN 2 8 2004

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DOCTORS COMMUNITY HOSPITAL Functal Director Functal Director Di	10d. Inside City Limits XX Yes 2 □ No What Country? STATES ICC - American Indian, Ick, White, etc. Ify: BLACK Business/Industry PRIVATE me) In, State, Zip Code)
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25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Ott 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occur	ner (Specify)
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29b. Signature of title of certifier 29d. Date signed DD 59 98 6 2 4	ed (Month, Day, Year)
D0059981 6/24	104
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Mukemil Abdella, MD 6005 Landover Road Suite3 Cheverly MD 20185	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

				State of Marylan 4a per phy G					_) 4 22403
	Physici /Medi		1. Decedent's Name (First, Middle, Last) JAMES WALTER KING					2. Date of Deat Month JUNE 28	Day	Yeer 3. Time of Death 5:04P M
	Examir		4a. Fail 215 Stratisticon, give s	Street			or Location of Dea	th	4c. County	
	Funeral Director		5. Social Security Number 6. Sex	TREET 7. Age (In yrs. I	Ven	If Under 1 Year Months Days		. (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
	ס		Usuel Residence of Decedent	60				SEP. 07	, 1943	WASHINGTON, DC
	a-f ahow	ctor	DC 10b. County	10c. City	y, Town or Lo WASHII					10d. Inside City Limits XXYes 2 □ No
	with the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Country?
	ns 23	Funeral	215 CONSTITUTION A	2 Was Decedent Ever in II	S. 13.		20002 Hispanic Origin? (5	Specify Yes or No-		ED STATES e - American Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f abow any injury or other traumatic avent, I'm Medical Exaction metal by notified at ance.	þ	1 Never Married XX Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 272 No If Yes, Give Year or Dates:	1	If Yes, specify Cub 1 ☐ Yes XX No	an, Mexican, Puèi Specify:	Specify Yes or No- rto Rican, etc.)	Blac	BLACK
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Ž	Should nd Me mark mark	၉	WALTER LEE KING, S 19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street	·	'A PERRY Jural Route Number	City or Town,	State, Zip Code)
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altimore,	Pages 1. ent of He nt: If iten ry or oth		20a Method of Disposition AB Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	emetery, crei	osition (Name of matory or other pla HEAVEN CE		Date UL 2004		City or Town, State
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Ucer'se	HOME OF	MARYLAI					
	- A		23a. Part1. Enter the disease, or complice shock, or learn failure. List only on	cations that caused the death		308 SUITI ter the mode of dyi				Approximate Interval Between
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	PANCREATIC Due to (or as a consequence)		R WITH LI	VER META	STASIS		Onset and Death 3 MONTHS
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	To the To the Complet	Me	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed	(Month, Dey, Year)
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表	Sta	te	DAVID J. PERRY 31. Date filed (Month, Day, Year)	32. Registrar's Signa	U IRV.	ING ST. N	IW WA	SHINGTON,	DC 200	J10
	Regist		1111 0 2 2004	aux Mr Do	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** <u>12:</u>45₽[™] June 23 2004 Nora Jeanne Kline /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Crofton Crofton Convalescent Center Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sep. 3, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □ M 2 🗓 F 77 1926 Wash., 579-34-0423 D.C. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner must be rediffied at once. 10a State 10b. County 1 Yes 2 No Director MD Anne Arundel Annapolis 10c. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2618 Compass Drive 21401 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora K. Gehr ဂ္ Stanley A. Hertzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1323 Pleasant Meadow Rd. Donald S. Kline / Son Crofton, MD. 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crem. 6-24-2004 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licens 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition years Atherosclerotic Heart Disease **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed for use as the burial-transit Aspiration Pneumonia weeks and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 Yes 2 No Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 No 3 DOA 1 Yes 2 ER/Outpatient 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation 2 Accident the **Director**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide after ō within 24 hours a To the Hospital 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) JUN 2 8 2004

Rakesh Arora,

14300 Gallant Fox Ln. Bowie, MD, 20715 M.D. . Registrar's Signature

		1	For State	State of	Marylar	•	artment of H		Mental Hy	/giene	nnl.	221.05	
			Registrar 1. Decedent's Name (First, Middle, La	st)					2. Date of D] [] 4	3. Time of Death	_
	Physicia	_							Month 06	21	Year 04	10:45 P N	и
	/Medic		Donald Lee King 4a. Facility Name (If not institution, give		nber)		4b. City, Town, or	Location of Dea			ounty of Death	10.45	
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	Funeral		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	if Under 1 Year	If Under 24 Hr	s. 8. Date of B		9. Birth	place (State or Foreig	gn
-	Director		578-60-6828	☆ M 2□F	57	Yrs.	Months Days	Hours Min		L4 47		ngton, D.	C.
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<u>a</u>	lid be lenta rked ifc ev	To B	John Benjamin K	ing, Sr.				Marga	Virgie	Delane	y		
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#	-0/		Dr. David Cro	•			ersity B	lvd. Eas	t Silve	r Spri	ng. Md.	20910	
H	Sta		31. Date filed (Month, Day, Year)	32. F		nature				-			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 25,2004 Edith June Lewis 11:03 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PGClinton Southern Maryland Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign May 13, 1935 | D.C. | 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 69 577-48-2561 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show notified at Yes 2□No Md. Oxon Hill Director Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code . Peges 1 and 2 should be filed within 72 hours after death with irnent of Health and Mental Hyglene. Intent of Health and Mental Hyglene are retained; or Items 23a or it and end of the than "natural; or Items 23a or it 20748 USA 5701 Livingston Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 XNo Specify: Maryland 21215-0036 Ş A 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Home-maker/Minister Religeous 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lewis Isabell Lewis Roosevelt Lewis Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5701 Livingston Road, Oxon Hill, Md20748 Willie J. Lewis (Husband) Important: If item 2 any injury or other once 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Rusurrection Cem. 6/30/2004 Clinton, Md. 22. Name and Address of Facility Tri-State F/S/Inc.21. Signature of Funeral Service Licensee permil Depa 912 Third St. NW., Wash. D.C. 20001 long! mas 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHANI Pnysician /Medical Due to (or as a consequence) Examiner lew) c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consent Examine Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 ☐ Yes 2 ☐ No 200 1 Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Compatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manher of Death Natural 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 24 hours after of Funeral Direct 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. 124 MD 11701 Lyling 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

04-4120)		Please					t of Health and			•	
			1 _ State 6-29-04		•	-		t of Health and e of Death	-	gierie Reg. No.	con an a	00107
	- '5+		Registrer Amend# 28a.P 1. Decedent's Name (First, Middle, La				moun	0 01 000111	2. Date of De	ath	ـــنېدارخار	3. Time of Death
	Physicia /Medic			Lopez					JUNE 1	23,	2004	7:00 P M
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	Funeral Director			Sex 7. Age 1 X M 2 ☐ F	19	st birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs Days Hours Min.		y, Year)		place (State or Foreign intry) cemala
	show	<u>.</u>	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1X Yes 2 ☐ No
	the Ma	Director	Maryland Prince 10e. Street and Number	George's	Ну	attsv:	ille 10f. Zip	Code		10g. Citiz	zen of What Cou	
	th with 23a or		1521 Kanawha Str	eet #207				20783		Guat	emala	
	after deat or Itams 2	Funerai	11. Marital Status	12. Was Decedent B	Ever in U.S.	. 13. V	Vas Deced	dent of Hispanic Origin? (Softy Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)		14. Race - Amer Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hyglene. thar then "neturel", or Items 23a or 28e-f show ont, Ite Medical Eraniner must be neitlied at	þ	1 🎇 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🖔 N If Yes, Give Year or Dates:	40		I X Yes ∶		atemalar	-	C'4	ispanic
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anc	d be f	o Be	Ovidio Jordan	7				_	ınza Lope			
Maryland	shoul nd Me marl	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street and Number or R	-		Town, State, Zi	ip Code)
Š	alth a		Alirio Jordan-Ca	rrera - Br	other	1521	l Kan	awha Street	#207, Hy	atts	ville,	MD 20783
ore	es 1 and 2 should be filed of Health and Mental Hygie f fiam 27 is marked othar ir other traumatic event, II		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [XI Removal from State	20b. Pla	ce of Dispo netery, cren	sition (Nan natory or o	ne of ther place)	Date	20c. Loc	cation - City or T	own, State
Ĕ	Pages ment of h ant: If its lury or of	8	* 4 ☐ Donation 5 ☐ Other (Speci	ify)	Cemen			Camotan 07/0	1			Guatemala
Baltimore,	permit. Pages: Department of H Important: If its any injury or ot		21. Signature of Funeral Service Lice		10 10 0			d Address of Facility Ga				
_	40 = 8 d		23a. Part1. Enter the disease, or cor		the death	,		altimore Ave			le, MD	20781 Approximate
	Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each ling	10.	20 110, 011.	01 1110 11100	0 0, 0, 1, 1g, 000, 1 ac 001 ac				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):						
C-1	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Clistate of killing)	b. Due to (or as	a conseque	ence of):						
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	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnan	CM/						
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant at	2 Fetal c	ieath 3	Ectopic pr Other (sp			2	3d. Date of deliv Month	Day Year
<u>8</u> .	res that the de signed by the a be detached	ρ	Part II. Other significant conditions	contributing to death b	ut not result	ting in the ui	nderlying c	ause given in Part I.	23e. Did t	_		the cause of death?
oro	w requir been si should	eted							24a. Was			opsy findings available
Division of Vital Records,	The law cate has page 2	Completed							auto	psy prmed?		ompletion of cause of
Vita	ician: certific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Date	ath (Check only o			15 00m F
ō	Phys r this ral dir	- L	1 X Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 2	R/Outpatien 28b. Time of	_	4 Nursing	Home 5 Resi 28d. Describe			fy) AT SCENE
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Oivisi	or Attar after dea Director in by the	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Injuding, etc	ury - At hom c. (Specify)	ne, farm, str	eet, factory	N PLACE)	City or To	wn. State)	}	al Route Number,
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical Co		hysician: To the best	of my know f examination	ledge, death	occurred	at the time, date and place, in my opinion, death occ	e, and due to the	cause(s)	and manner as	stated.
	o the	Med	29b. Signature and title of certifier	and manner sta	2.00.		290	c. License number		29d. Date	e signed (Month	Day, Year)
	8 48 4		▶ ane I					O.C.M.E		JU	NE 24,	2004
CR	(6)			310, MD	leath (Item :	23a) (Type, 11 Per	erint) nn St	reet, Baltin	ore, Mai	rylan	d 21201	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 2004	32. Registra	ar's Signatu	- Local	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Registrar # 7 per pg

1. Decedent's Name (First, Middle, Last) 7/7/04 2. Date of Death Year Month Physician A. LaRoach 07:08 PM James 24 2004 JUNE /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CAMP SPRINGS

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Day, Year 941 Country)

Print Days Hours Min. (Month, Day, Year 941 Pittsburgh Pa MALCOLM GROW MEDICAL CENTER 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 13M 20F 63 367-42-5073 Yrs. 1911 Pittsburgh Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2 ☐ No Director MD Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò United States or items 23e 3703 Cricket Ave 20747 death Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Depertment of Health and Ahould be filed within 72 hours after conspection of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Madical Examinations." 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 35 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2000 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James A. LaRoach Sr. Mary Lee Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary LaRoach / Wife 3703 Cricket Ave Forestville MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-16-04 Arlington National Arlington Cometery Name and Address of Facility Pope Funeral Home 21. Signature of Funeral Service Licensee Cloria 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. HYPOTENSION 08 HOURS /Medical Due to (or as a consequence of): **Examiner** INFECTION-INTRABDOMINAL 08 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probabiy 4 Unknown CHRONIC RENAL INSUFFICIENCY Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🗶 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by t 4 Homicide To the Hospitel c within 24 hours af To the Funarei Di filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) 89 MDG/ 1050 W. PERIMETER RD.

DANDA, News 27 200)

USAF, MC

. Registrar's Signature

DAVID A. NORTON, MAJ,

JUN 3 0 2004

31. Date liled (Month, Day, Year)

MD-071370-L

PA

ANDREWS AIR FORCE BASE, MD 20762-6600

JUNE 24, 2004

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П	Physicia	an	Decedent's Name (First, Middense Georgiana	lle, Last)		Lancas	ster				Jul 12,		Year	3. Time of De :57 am	eath M
	/Medic Examin		4a. Facility Name (If not institution	on, give street and			4b. City,		Location o	of Death	001 12,	4c. County		.or ain	
			Frostburg Villag					stbur	g If Under :	24 Hrs	O Date of Birth	Allega		(6)	
ı	Funeral Director		5. Social Security Number 214-07-3084	6. Sex 1 ☐ M 2 🕱		(In yrs. last birtho	Months	Days	Hours	Min.	8. Date of Birth Month Day, OCT 25,	1909	9. Birthpi	ace (State or F	oreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	у		10c. City, Town o							10	Od. Inside City I	Limits
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	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show the Mardical Examination and Le molified at	by Funeral Director	10e. Street and Number 398 McHenry S	Street			10f. Zip		21502		1	0g. Citizen of U	What Coun SA	try?	
	ems 2:	ınera	11. Marital Status	·Arme	Decedent E	ver in U.S.	13. Was Deced	dent of Hi	spanic Orig	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		ce - America		
336	ursafte al', or li	by F.	1 Never Married 2 Ma 3 Widowed 4 □ Divorce	If Ves	/es 2 ☑ No s, Give or Dates:	0	1 ☐ Yes	2 No	Specify:			Specif	y: white	9	
2-0	72 hor	eted	15. Decede (Specify only highe	nt's Education est grade comple	ted)	(0	ecedent's Usua Sive kind of wo	rk done a	lurina most	of working	ng	16b. Kind of B	usiness/Ind	lustry	
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	ould ba filed a Mental Hygisharked other hatic event, I	Be	17. Father's Name (First, Middle George H. B				_				(First, Middle, I rbara Hu		•	ockev	
*	5 5 5 5	2	19a Informant's Name/Relation Raymond Lanc		son	19b. A	lailing Address	(Street a			Route Number				
aî.	1 and 2 Health lam 27 l		20a. Method of Disposition			20b. Place of D	isposition (Nar	ne of				20c. Location			
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or other trau once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (rom State	SS Peter	& Paul C	emete	ery	7	7/15/2004	Cumbe		MD)
Balt	permit. Pages 1 Department of H Important: If ita any injury or ot once.		21. Signature of Funeral Service	Licensee	Jane (Q-	22. Nam g 27				me, PA Cumberla	and, MD	21502		
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Du	e to (or as a	consequence of)		6							
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P.O. E	that the dealed by the at	ysici	1 ☐ Yes 2 ☑No 9 ☐ Unknown		Pregnant at t Jiknown	ime of death	5 ☐ Other (sp	ecify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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sion	Attending Ph ir death. actor: After th by the funeral	atio	Z _ Accident	tigation	Month, Day	Year) Inju	M	Work	r? Yes 2∐t	No					
Division	I or Att after de Diract d in by t	Certification;		mined 288. F	Place of Injui ouilding, etc.	ry - At home, farm (Specify)	, street, factory	, office		2	28f. Location (St. City or Town		oer or Rural	Route Number	5
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical C		ing Physicien: To I Examiner: On tand		examination and/									
	To th within To th compl	Me	29b. Signature and title of certifi	er			290	. License	number		2	9d. Date signe	d (Month, E	Day, Year)	
1			30. Name and address of person	Sylling sylleted	cause of de	ath (Item 22s) (T-		D269	07			July 12	,	2004	
	2		Harjit S. Sidh					oad;	Cumb	erla:	nd, MD	21502	·		
	Sta Registr		31. Date filed (Month, Day, Yea. JUL 1		32. Registra	r's Signature	9 1	2 10		1					

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AMEND THE #2/ PER ME 6833

State of Maryland / Department of Health and Mental Hygiene Amended, #20c, 1- State Registrer F.H., TCHD, 06/22/04, sbb Certificate of Death Reg. No. | | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** KARL 1125 AM 06 20 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHOCK TRAUMA BACTMONE, MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2□F XX Months Days Hours Yrs. Director 216-38-9922 9,1914 Germany Usual Residence of Deceden 10b. County 10c. City, Town or Location ahow 10a State 10d. Inside City Limits raumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director MD. Talbot st. Michaels 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 204 w. Chew Ave. 21663 U.S.A. Items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after de It Hygiene. other than "natural", or Item 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement 10 House Painter other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental I Karl Hugo Liebig Fraziska Popanda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 301 Shilling Dr. Centreville, Md. 21617
ace of Disposition (Name of Date 20c. Location - City or Town, State Klaus-Dieter Liebig/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of the Important: If ite any injury or ol once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Dover, Delaware * 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 6-22-04 Dover, Dalaware 21. Signature of Funeral Service Licensee De. R. Carroll Hurley Funeral Home P.C. Dover, I oseph M. Ostnanki 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as arriac shock, or heart failure. List only one cause on each line. £t. Michaels. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MEDICAL EXAMINER stemos/s /Medical Due to (or as a consequence of Examiner Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CEMPEATON APPROVED BY Examiner burial-transit Krantune Due to (or as a consequence of). Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2) No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA 1XYes 2 No 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; Hospital or Attending Accident 5 Pending 6/11/04 :00 1 ☐ Yes 2 👿 No [all From STANDING HEIGHT investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2/6/3 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Hong 204 W CHEW AVE, STMICHAES, MO 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month. Dav. Year) D0059146 6/20/04 Jolpson, mo 0000 SHOCK TRAUM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffery L. Johnson, mo 22 South Green St 31. Date filed (Month, Day, Year) JUN 2 2 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day A M 29 Williamson Luzadder 2004 Lance June 12:09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Leonardtown St. Mary's Hospital
5. Social Security Number 6. Sex St. Mary's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Birthplace (State or Foreign Country) Hours 1**X** M 2□ F Director 21 228-47-6632 Jan. 28, 1983 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at VA 1 ☐ Yes 2 ☑ No Directo Loudoun Sterling 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 254 N. Cottage Road 20164 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ₩ Never Married 2 Married 1 ☐ Yes 2X No 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Shite þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Student School 1 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avent ODGs. 18. Mother's Name (First, Middle, Maiden Sumame) Be Gary Steven Luzadder Claudia Anne Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 254 N Cottage Road Gary S. Luzadder - Father Sterling, VA 20164 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State
4 Donation 5 Other (Specify) Adams-Green 06/30/2004 Herndon, VA Funeral Home 21. Signature of Funeral Service Licensee Adams-Green Funeral Home him 721 Elden St., Herndon, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carohac one Day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been si 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 1 ☐ Yes 2 No this After this funeral o 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending Injury 1 Tyes 2 No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) SCGaby M.D. D54346

DHMH 17 Rev 1/2001

State

Registrar

ANCE LUZADDER

ORIGINAL

Dean & Species .

P.O. BOX 640 PHILIP J. BEAN MED CTR. HOLLYWOOD, MD. 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHANDRA SAJJA M.D.

31. Date filed (Month, Day, Year)

	,	3	For .		Maryland / De		t of H	lealth a	and Mer	ntal Hyg	•	. 221.12)
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Baltimore,	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□ Domovel from Cto	20b. Place of Dicemetery,	sposition (Nan crematory or o	ne of ther place	e) .T111	Date O	2004	20c. Location - Cit	y or Town, State	
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	•	For State Registrar		•	partment of F ertificate of			Reg. No	NL	221.13
		1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	aath Day	Year	3. Time of Death
nysicia Medica		Kenneth	Lee	Linton	Sr		July		004	11:08pm
mine		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, o	or Location of Death			y of Death	
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al		5. Social Security Number 217-28-5645	5. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jul 12	th ay, Year)	9. Birthp	place (State or Foreigntry)
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	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	Funeral Director	624 Knoxville	Road			217 58		U.S	.A	
	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No)- 14. Ra	ce - Americ	
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1		19a. Informant's Name/Relationsh Mrs. Janice M.			ailing Address (Street					
ı	-	20a. Method of Disposition	TTUCOU/WII		24 Knoxvil		NNOXVII	.1e, Mar 20c. Location		
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ı	Š	29b. Signature and title of certifier			29c. Licens			29d. Date signe	-	*
			2	ins	D14	626		July 09	, 200)4
			the completed cause of	death (Item 23a) (Tv	pe. Print)	777				
		30. Name and address of person v	combiered canse of	again (man East) (.)						
÷		P. Gregory R				treet, Fr	ederick	k, Maryl	and 2	21701

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		•	For State Registrar		-	ertificate of		Reg. I	2001	22414
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	Physicia /Medic		Elizabeth Marie	Lazarcz	V			June 3	30 2004	4:10 A M
	Examin	er	4a. Facility Name (If not institution, given St. Gertrude's In				or Location of Death	-	4c. County of Death	
E	uneral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. last birtho	Ridgel	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Carolin	e aplace (State or Foreign untry)
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and	A	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
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ter de	Itams	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces: 1 Yes 2 X	Ever in U.S.	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Spi pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
036 iurs af	Exam.	۵	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
5-0	natur	Completed	15. Decedent's Ed (Specify only highest gra		(0	ecedent's Usual Occu	during most of work	ing 16b.	Kind of Business/le	ndustry
121 within	than ta Me	du	Elementary/Secondary (0-12)	College (1-4or	5+) lii	e. DO NOT use retire		r.a	lucation	
d 2 filed	ont.		12 17. Father's Name (First, Middle, Last,	5+		Teacher		e (First, Middle, Maid		
rian uld be	rked tic ev	To Be	Edward Lazarczyk				Juli	a Jenkot		
Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hyolene.	ls ma auma		19a. Informant's Name/Relationship (al Route Number, City		p Code)
e, N	Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. Its Medical Examiner must be notified at once.		Sr. Gerard Falkow 20a. Method of Disposition	sko Pri		259 Benedi sposition (Name of		Ridgely,	Maryland Location - City or T	21660
Baltimore,	t: If It y or o		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		cemetery,	crematory or other pla trude's			dgely, Ma	
altir mit. P	injur		21. Signature of Funeral Service Licer			metery 22. Name and Addre	ess of Facility		,	
m & a	lmpo any ir		12018	u	/	Fleegle an PO Box 160	d Helfenb	ein Funera baro, Mary	II Home PA	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death. Do not ine.	enter the mode of dyi	ing, such as cardiac	or respiratory arrest.	Iunu 21	Approximate Interval Between Onset and Death
	sician edical	Î	Immediate Cause (Final disease or condition resulting in death)	a. TTCU	te (ARDIT	tc F	41LURE		1 week
	miner			Due to (or as	a consequence of):			•		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
60, be executed	attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.						
760,	ician a	cai Ex	Tosaking in doubly cast	Due to (or as	a consequence of):					
687 lifficate	phys is the	_		_ d						
. Box 68	anding use a	IN/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 Ectopic pregnanc	***		23d. Date of deliv	
O. B	the att	Physician/Med	in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	4☐Pregnant a		5 ☐ Other (specify) _	·y		Month	Day Year
ords, P.O	as been signed by the 2 should be detached	Phy	Part II. Other significant conditions of	contributing to death I	out not resulting in th	e underlying cause or	ven in Part I.	23e. Did tobacci	o use contribute to	the cause of death?
dS,	signed Id be det	d by	PARKINSO	1 2MC	DKEA	SE.		1 ☐ Yes		bably 4 Unknown
	s been should	olete	LISUV BO	DV D	EME	MITA	-	24a. Was an	24b. Were aut	opsy findings available
Pec The law	page	Completed		1	7 7 7 7			autopsy performed?	death?	ompletion of cause of 2 No
of Vita	量る	Be	25. Was case referred to medical examiner?	Manital		100		h (Check only one)		
2 5 had	<u>\$</u> 5	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji		tient 3 DOA		me 5 Residence 28d. Describe how in		fy)
Vision Attending	: Afte	ation	1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year) Inju	ry Wo	ork?]Yes 2 □No		,,	
Division tor Attending	recto	Certification;	3 Suicide 6 Could not b	286. Place of In	jury - At home, farm tc. (Specify)	, street, factory, office		28f. Location (Street City or Town, Sta		al Route Number,
Dia	illed in	Cer	CO. Continu							
Divisio To the Hospitat or Attendit within 24 hours after death.	To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best miner: On the basis of and manner st	of examination and/o	eath occurred at the ti r investigation, in my	ime, date and place, opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as a and place, and due t	tated. the cause(s)
To the	То th	Me	29b. Sometime and what of certifier	a · ma	1100	29c. Licen	se number	29d. D	Date signed (Month,	Day, Year)
			1 Jens	m/1/D		21	4666	t Ju	1402	- 2004
			30. Name and address of person who	completed cause of	death (Item 23a) (Ty	Print HA	90 D	DITON!	MO	7//20
	Stat	e	31. Date filed (Month, Day, Year)	3 Regist	rar's Signature	UDITE	Wys	= NWN	1414)	1621
	Registra		JUL - 7 201	14 Back	V 1. 10	23.1/2				

OCME

JULY 8, 2004

111 Penn Street, Baltimore, Maryland 2120

30. Name and address cal se of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 1 5 2004

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

DH v.H 17 Rev 1/200

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** \mathbf{A}^{M} MCKINNIE JUNE 24, ROBERT Sr. 2004 WILLIAM 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9007 Volta Street Prince George's Lanham If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs North Carolina Director 244-22-5361 79 14 1925 Usual Residence of Decede the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 7 is marked other than "natural", or Items 23s or 28s-f shor traumatic event, the Medical Examinating that be exciting at 1 Yes 2 No Directo Prince George's Lanham 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20706 U.S.A. 9007 Volta Street death Funerai 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Amned Forces 19713/1950 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates 08/07/1952 Specify: BLACK þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Truck Driver Private 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) iit. Pages 1 and 2 should be file ariment of Health and Mental Hy ortant: If item 27 is marked oth injury or other traumatic event Be ဂ္ Eddie R. McKinnie Clemmy McRae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Leake 3209 Barcroft Drive Springdale, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o * 4 ☐ Donation 5 ☐ Other (Specify) 7/1/2004 Laurel, Maryland Maryland National 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the die complications that shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-t 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide hours after within 24 hours a

To the Funeral E

completely filled i **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0031311 MD JUNE 25, 2004 M. D. leish 30. Name and address of person who completed caus: of death (Item 23a) (Type, Print) ROBERT WADLEIGH, M.D. VA MEDICAL CENTER, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) State JUN 3 0 2004

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		ľ	1 _ Stete	ate of Maryland / Depa	artment of Health and rtificate of Death		ne No 2 A A L	001.15
	0		Registrar 1. Decedent's Name (First, Middle, Last)		timodio or Dodin	2. Date of Death		3. Time of Death
×	Physici /Medic		Doris D. Means			Month 06	Day Year 22 04	3:06 P M
	Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Dea		4c. County of Dea	
	;		Holy Cross Hospita	1	Silver Spring		Montgome	ry
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 2 🔀 F 77 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yo	ear) Co	thplace (State or Foreign ountry)
	Director	-	577-32-9099 Usual Residence of Decedent	77 Yrs.		March 27	,1927 Was	hington, D.C
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary 1 sh	to	DC	Washing	ton			1 <u>f</u> Yes 2 ☐ No
	r 28c	irec	10e. Street and Number	, wasiiiii	10f. Zip Code	10g.	. Citizen of What Co	ountry?
	th wit	alD	130 Longfellow Stre	et N.W.	20011		USA	
	be filed within 72 hours after death with the Maryland stal Hygiene. od other then "neturel", or Items 23a or 28e-1 show event, the Musical Exam avent, the Musical Exam we man the musical at	Funeral Director	11. Marital Status	/as Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fu	_ If	☐ Yes 2 XNo Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: B1a	
Ö	hour ture	q pa	3 Widowed 4 □ Divorced Y 15. Decedent's Education	ear or Dates:	dent's Usual Occupation	161	b. Kind of Business	
15	in 72	Completed	(Specify only highest grade con	npleted) (Give	kind of work done during most of wo DO NOT use retired)	orking	b. Killo of Business	moustry
212	d with giene.	шо	Elementary/Secondary (0-12)	ollege (1-4or 5+) 4 yrs.	Teacher	D.	C. Public	c Schools
þ	should be filed within and Mental Hygiene. s marked other then " umatic event, the Me	Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, Mai	iden Sumame)	
/lai	uld b Wents urked	To E	Lee A. Daughtry		Alma (Clyburn		`
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 Is marked c other treumatic eve		19a. Informant's Name/Relationship (Type, F	Print) 19b. Mailin	ng Address (Street and Number or F	Bural Route Number, C	ity or Town, State, I	Zip Code)
	and ealth m 27	1 10	Arlene Means/Daught		Greenly Street S			
ore	ges 1 t of H if itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove		natory or other place)		c. Location - City or	
Ë	tment tent:		`4 ☐ Donation 5 ☐ Other (Specify)	Fort Line	i		entwood,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 It eny injury or other tre once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility MA			
	40300		23a. Part 1 Enter the disease, or complication		217 9th. St. N.W.			20011 Approximate
			shock, or heart failure. List only one ca	use on each line.		ic or respiratory arrest,		Interval Between Onset and Death
	Pnysician /Medical	9 9	Immediate Cause (Final disease or condition resulting in death)	cute Cerebrovasc	ular Accident			
	Examiner		1	Due to (or as a consequence of):				
į.	Te ne	e.	Sequentially list conditions, b. —	Due to (or as a noneequance of):				
	uted d ansit	Examiner	rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury that infliated events					
ó	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or as a consequence of):			-	
8760,	te be ysicia ne bui	dical	d					1
9	rtifica ng ph	Jed	IF FEMALE:					
Вох	the death certificate be executed y the attending physician and tched for use as the buriat-transit	Physician/Me	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy □Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of del	
_	ne dea the at hed fo	sici		☐ Pregnant at time of death 5☐ ☐ Unknown	Other (specify)		Month	Day Year
P.0.	that the di ed by the detached	Phy	Part II. Other significant conditions contribu	ting to doub but not coculting in the	adachian anna anna is Dact I	22a Did tabaa	an use contribute to	the cause of death?
	requires that een signed b hould be deta	by a	Pneumonia	ing to death but not resulting in the d	ndenying cause given in Fait i.	1 ☐ Yes		
Records,	w requires to been signed should be	Completed	Hypertension					
Sec	e la has je 2	mpl	- in percentation			24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
al	icien: The l certificate ha ector, page					performed 1 ☐ Yes 2 🖺	No 1 ☐ Yes	2 🗆 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospi	al: 1 ⊠Inpatient 2 ☐ ER/Outpatier	Other	ath (Check only one)	о Пон <i>(</i> 2	
of	Phys or this oral di			a. Date of Injury 28b. Time of	f 28c. Injury at	Home 5 Residence 28d. Describe how i		ciry)
lon	Attending F r death. ector: After by the funer	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attend after death Director: /	Hice	a □ Cuicido 6 □ Could not be	te. Place of Injury - At home, farm, str	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru	ural Route Number,
ā	s afte	Certification:	4 () Hornicide	building, etc. (Specify)		City of Town, 3	iate)	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by			n: To the best of my knowledge, deat On the basis of examination and/or in				
	the H in 24 the F iplete	Medical	one)	and manner stated.				
	To the I within 2: To the I complet	Σ	29b. Signature and little of certifier		29c. License number		Date signed (Monta	
•			MANITY	MP	DS 4347	00	6-22-2	004
P	. 151			ited cause of death (Item 23a) (Type,				
	()		Dr. Neeraj Chopra 31. Date filed (Month, Day, Year)	P.O. Box 83819	Gaithersburg, MD.	20883		
* 2	Sta Registi			Steele & Span	2,			
	ed :	2 -		The Party of				

DHMH 17 Rev 1/2001

MEANY DORIS

			1 - For Stete Registrar	State of	Marylan		artment rtificate				ntal Hygi	ene g. No. 2	14	221.10
	Physici /Medic		Decedent's Name (First, Middle, Hope	Last)	McDo	onald					Date of Death Month June 26	Day Y	'eer	2:15 PM
	Examir		4a. Fecility Name (If not institution, 6829 Nashville		oer)		4b. City, T Lanh		Location o		4c. County of	4c. County of Death Prince Georges		
	Funeral Director		128-28-2324	6. Sex 1 □ M 2 🗗 F	Age (In yrs. 68	• /	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min	Date of Birth (Month, Day, ULY II	^{Year} , 1935	. Birthplace Country) New	(State or Foreign York
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28e-f show polical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number	e George's		y, Town or Lo		nhan	1		10	g. Citizen of Wha		Inside City Limits 1√2 Yes 2 □ No
	eath with		6829 Nashvii	Lle Road	ent Suar in II	6 12 1		20	706	nin2 (Ci		U	JSA	
900	ours after d	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3X Widowed 4 Divorced	Armed Forc	es? ☑No	'	f Yes, spec		Specify:	gin (Speci i, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	l within lene. r than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Elementary/Secondary Designe							1		bb. Kind of Business/Industry Private		
yland;	ges 1 and 2 should be filed it of Health and Mental Hygi If item 27 is marked other or other traumatic evant, I	To be the second of the second									First, Middle, M Tazen	aiden Sumame)		
	and 2 sho ealth and m 27 Is m		19a. Informant's Name/Relationship (Type, Print) Jon McDonald (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City o. 934 Fall Ridgeway, Gambrills MD											de)
Baltimore,	permit. Pages 1 Department of Hi Important: If iter any injury or oth		1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State									oc. Location - Cit Beltsvil Funeral n MD 207	le, M Hame	
	Physician /Medical Examiner	۲	23a. Part. Enter the disease, or conditions and the condition resulting in death)	_a. Breas	_	h. Do not ent	er the mode	of dying	, such as	cardiac or r	espiratory arres		Ap Inte	proximate erval Between set and Death Months
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequate as a consequate									
.O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏ Fetel ntattime of de	Ideath 3□	Ectopic pre					23d. Date of delivery Month Day Year		
ds, P	8 5 0		Part II. Other significant condition	s contributing to deal		ulting in the ur	iderlying ca	use give	n in Part I.		23e. Did toba	icco use contribu		ause of death?
of Vital Record	The law ate has b page 2 sl	Completed by	chronic obs	tructive	pulmo	nary	dijed	ise			24a. Was an autopsy performe 1 ☐ Yes 2 €	prior deal	r to comple	findings available tion of cause of
Vita	certifi rector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ationt 2	ER/Outpatien	3□ DOA	Othe	_		Check only one	11 11 11 11 11		
ion of	ding h. After fune		27. Mann of Death 1 Autural 5 Pending 2 Accident investiga	28a. Date of (Month,		28b. Time of Injury		c. Injury Work		280		ce 6 ⊡Other (rinjury occurred	<i>ъресну)</i>	
Division	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of	Injury - At ho , etc. (Specify	ome, farm, stre	et, factory,	office		28f	Location (Stre City or Town,	et and Number o State)	or Rural Ro	ute Number,
	he Hospitel in 24 hours a he Funerel I pletely filled	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the be xaminer: On the basi and manner	s of examinal	wledge, death tion and/or inv	occurred a estigation, i	t the time in my opi	e, date and inion, deat	d place, and h occurred	due to the cau at the time, dat	rse(s) and manne e and place, and	er as stated due to the	l. cause(s)
1	To the complet	Σ	29b. Signature and title of certifier	fu)		29c.	D 2	number -2.7	80	290	1. Date signed (M	donth, Day,	Year)
2	(5)		30. Note and address of person we leter M Schill	le MD 3	of death (Item	(Type, I	orint)	Ctr	Dr.	Cree	enbelt,	6-28-	770	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 9 20	04 2. Reg	istrar's Signa	ture	K							

		For State	State of Ma	-	artment of H			giene	22420
		Registrar 1. Decedent's Name (First, Middle, Li	ast)		Timeate of I	Douin	2. Date of Dea	ith	3. Time of Death
Physici		JUDITH LOTTIE					Month JUNE	Day Year 2004	9:30A M
/Medi Examir		4a. Fecility Name (If not institution, gi			4b. City, Town, or	r Location of Death		4c. County of Dea	th
		2031 BROOKS DR				ESTVILLE		PRINCE	
Funeral	9		Sex 7. Age 1	(In yrs. last birthday 62 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year) Co	thplece (State or Foreign ountry)
Director		168 34 5626 Usuel Residence of Decedent		62			APR. 11	, 1942 FEI	NNSYLVANIA
yland how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits XIX Yes 2 □ No
Ba-fs	Director	MARYLAND PRINCE	GEORGES	FORESTVI				100 Civings of What C	
with th		10e. Street and Number	#212		10f. Zip Code	747		10g. Citizen of What Co	
eath y	Funeral	2031 BROOKS DRIVE	1/ Z I Z	ver in U.S. 13.	Was Decedent of H		ecity Yes or No-		erican Indian,
or Itam	표	1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)		
ours a	db	3 ☐ Widowed 4XX ivorced	If Yes, Give Year or Dates:					Specify: BL	
i. K. I.3-0030 within 72 hours after death with the Maryland ene. than *natural', or Itams 23e or 28e-f show he Madical Exemine must be nutilised at	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of worki	ing	16b. Kind of Business	/Industry
withir ene.	dmc	Elementary/Secondary (0-12) 12TH	College (1-4or 5+	-)	ECRETARY	-7		FEDERAL	GOVERNMENT
be filed tal Hygid d other	Be Co	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle,	Maiden Surname)	
should be nd Mental marked c	ToB	BELMON DEAN, SR.				EDITH E			
2 sho and and te me		19a. Informant's Name/Relationship						or, City or Town, State,	
ife, INIGITY IGITION A TAIN TO NOT STAND THE WARNIAN S 1 and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Modical Examinar must be nutitied at		DARA WELLS / DAU 20a. Method of Disposition	GHTER	20b. Place of Disc	1 BROOKS osition (Name of		5 FORE:	STVILLE, MI 20c. Location - City or	
Pages nent of the		XXX Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	,	ONT NAME ON		/ TIIN O	4 SUITLAN	ID MD
그 문원수		21. Signatur of Fundal Service Liv		1	ON NATION Name and Addre	ss of Facility			
Depariment of the popular of the pop		M. P. I	Marshe		308 SUITL		SUITL	MARYLAND, AND, MD 20	746
10 to 10 to		23a. Pert1. En er the disease, or co shock or heart failure. List on	mplications that caused by one cause on each line	the death. Do not e	nter the mode of dyir	ng, such as cardiac o	or respiratory ar	rest.	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_a METASTA	TIC COLOR	ECTAL CAN	CER			18 MONTHS
/Medical Examiner		resulting in death)	Due to (or as e	consequence of):					
A	e.	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
6U, be executed icien and burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
0 00	dicai		d						
box box box death certifical eattending phy of for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy			194111	23d. Date of de	alivery
BOX death cer attendir	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes XXX No	1 ☐ Live birth 4 ☐ Pregnant at t		☐ Ectopic pregnanc: ☐ Other (specify) _	у		Month	Day Year
by the	hysi	9 Unknown	9□ Unknown				-		
Ords, P.O. requires that the seen signed by the hould be detached.	by P	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying cause giv	ven in Part I.		obacco use contribute t	robably 4 Unknown
Ord requir	ted						101	781 -	
HECOTOS The law requires the has been sign sage 2 should be	Completed						24a. Was autop perfo	nev prior to	
_ ⊢ at ed	e Co	25. Was case referred to medical				26. Place of Deat	perfo		s 2 No
Of VITAL HER Physician: The lav this certificate has al director, page 2	To Be	examiner?	Hospital:	nt 2 ER/Outpati	ent 3 DOA Ott	200		dence 6 □Other (Sp	ecify)
On Of ding Phy h. After this funeral d		27. Manner of Death XX Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time		ry at rk?	28d. Describe h	now injury occurred	
ISIOR ttendir death. ctor: Af	catic	2 Accident investigat	tion			Yes 2□No	20/ 1 //	0	No. 1 Courts Alexander
DIVISION or Attending after death. Director: Afte	Certification:	4 Homicide determine		iry - At home, farm, : :. (Specify)	street, factory, office		City or Tox	Street and Number or F vn, State)	tural Houle Number,
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the funeral director.		29a. Certifier XIX Certifying	Physician: To the best of	of my knowledge, de	ath occurred at the ti	me, date and place,	and due to the	cause(s) and manner a	ıs stated.
	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occur	red at the time,	date and place, and du	e to the cause(s)
To the within 2 To the complet	×	29b. Bignature and title of certifier	ON CON	1. 10	29c. Licens			29d. Date signed (Mor	
20		Wohn E.	1 1 th	ngna	'	15185		JUNE 23, 20	004
(12)		30. Name and address of person wh			e, Print/ IRVING S	אנג נגוא ידי	SHINGTO	N, DC 2001	0
S	tate	JOHN E. MCKNIGHT 31. Date filed (Month, Day, Year)	■ Pogistra	r'e Signature		I NW WA	PHILIP	11, DO 2001	
Regis		JUN 2 8 201	04 Election	& Spe	WE				

4-0)4068			eartment of Health and Me		
RPD			1 - State Registrar C6 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg.	
	Physici	an			Month	Day Year 3. Time of Death
	/Medi Examir		David Roy Moncrieffe II 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June 20,	2004 0748 P M 4c. County of Death
	Exami	10.	Prince George's Hospital Center	Cheverly		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. g	Date of Birth	Q Birtholage (Ctato or Fornian
	Director		578-15-2154 12M 2□ F 24 Yrs. Usual Residence of Decedent		eb. 28,	1980 Washington Do
	land ow		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	Many B-1 sh	tor	DC Washi	ngton		1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. It health and Mental Hygiene. It is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examiner must be notified at	al Director	10e. Street and Number 444 Delafield Place NW	10f. Zip Code 20011	10g.	Citizen of What Country? USA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specif It Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fu	★Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	,	Specify: Black
Ş	tural	ed t	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16h	Kind of Business/Industry
215	nin 72 na "na Madik	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	'	
212	giene giene er the	Com	Elementary/Secondary (0-12) College (1-4 or 5+) Psycl	hologist Assistan	nt	Private
p	be filed ital Hygie of other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
yla	should tond Ment	2	David Roy Moncrieffe Sr.	Geraldine		
Maryland 21215-0036	12 sh h and 7 is rr traurr			ing Address (Street and Number or Rural F		· ·
	1 and Healt em 2	1 4	20a Method of Disposition 20b. Place of Disp	Delafield Place osition (Name of Date		hington DC 20011 Location - City or Town, State
JOI.	ages ant of it: If it		1 Donation 5 Other (Specify) 1 Burial 2 □ Cremation 3 □ Removal from State Rock Cre	matory or other place) \ \\ \\ \\ \ \ \ \ \ \ \ \ \ \ \ \ \	9-	shington DC
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		4 Bonanion & Bonner (openny)	2. Name and Address of Facility		
ä	permi Depa Impo any ir	1	170	1722 North Capito		's Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one causelon each line.	iter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
>,	Physician		Immediate Cause (Final disease or condition a. GVNSHOT WOVN	D OF ABBOME	= 1/	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	11,000110		
	Examiner	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury			
	be executed ician and burial-transit	Examiner	that initiated events c. Due to (or as a consequence ot):			
8760,	cate be e. physician the buria	dicai	d			
9		a)				
P.O. Box	eath certif attending for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
O. E.	it the death by the atte	sici		Other (specify)		Month Day Year
P.	that the ed by detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underhing cause green in Dart I	22a Did tobaca	o use contribute to the cause of death?
ds,	signed be det	d by	, and the result of the resulting in the	indertying cause given in Part i.		2 XNo 3 Probably 4 □Unknown
Vital Records,	w requir been si should	Completed			24a. Was an	
Re	he lav e has age 2	duc			autopsy performed?	
<u>e</u>		a	25. Was case referred to medical	26. Place of Death C	12 Yes 2 1	lo . 1⊠Yes 2□No
	Attending Physiclan: r death. ector: After this certifica by the funeral director, I	To B	examiner? 1 X Yes 2 □ No Hospital: 1 Inpatient 2 □ ER/Outpatie	Othon		6 ☐Other (Specify)
0	ding Ph h. After th funeral	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		d. Describe how in	ury occurred
sio	death. death. ctor: A / the fu	cati	2 Accident investigation 6 20 04 2:40		SVBJECT	was shot
Division of	after d Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Sta	
	spital	Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge deal			MOREAVE, MD
	Ho Full	edical	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, dear (Check only one) 1☐ Certifying Physician: To the best of my knowledge, dear (Check only one) 2☐ Medical Exeminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	29c. License number	29d. E	Pate signed (Month, Day, Year)
			· Quette	O.C.M.E.	Jur	ne 21, 2004
p	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Penn Street, Ba	ltimore,	Maryland 21201
	Sta Registr	4	31. Date tiled (Month, Day, Year) JUN 2 8 2004 Registrar's Signature	de		

			For State Registrar	State of	of Marylai	-	artment of I		ind Mental Hy	Reg. No?	14 221	22
	Physici		Decedent's Name (First, Middle William	, Last)	Ν	fallow			2. Date of De Month	, 2004	Year 12:12 at)eath≃ M ^M
	/Medic Examin	_	4a. Facility Name (If not institution Allegany County				4b. City, Town, Cumbe	rland	f Death	4c. County Allega	of Death	
	Funeral Director		5. Social Security Number 216-38-1847	6. Sex 1 M 2 □ F	7. Age (In yrs 64	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi Min. Sep 2	th , 1939	9. Birthplace (State or Country)	Foreign
Ī	Maryland f show	tor	Usual Residence of Decedent 10a, State MD 10b, County Alle	jany	10c. C	ity, Town or Lo Cumb	cation perland				10d. Inside City	
	h with the	al Direc	10e. Street and Number 13314 Jade Stre	eet			10f. Zip Code	21502		10g. Citizen of V	•	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23e or 28e-f show may injury or other treumatic event, it is Medical Examination to cliffied at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed F	2 No	'	Was Decedent of f Yes, specify Cub		gin? (Specify Yes or N Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036		ompleted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed,) (1-4or 5+)	16a. Deced (Give life. L Labore	dent's Usual Occu kind of work done DO NOT use retire	pation during most ed)	of working		ers Local	
and	12 should be filed within h and Mental Hygiene. 7 Is marked other then "Ireumatic event, the Mes	To Be C	17. Father's Name (First, Middle, a Guy Mallow	ast)					r's Name <i>(First, Middle</i> nie E. Cunr	, Maiden Suman	ne)	
Maryland	and 2 shou ealth and M n 27 is mar ier treumsti		19a. Informant's Name/Relations! Janice Mallow	nip (Type, Print) W	rife	19b. Mailir 133	ng Address (Stree	t and Number	r or Rural Route Numb			2
Baltimore,	Pages 1 and inent of Health int: If item 27 ary or other tr		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	City or Town, State	 ጋ							
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service (icensee / cu	well	22			al Home, PA enue: Cumbe	rland, MD	21502	
	Cate be executed Wedical Examiner the burial-transit	dical Examiner	23a. Part Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Secuentially list canditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to c.	eách line. (or as a conse	quence (f):		ICE			Interval Betwe	een rath
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	utcome of pregr birth 2 Fet mant at time of nown	al death 3 ☐	Ectopic pregnance Other (specify)	;y		23d. Dai Mo	e of delivery nth Day Ye	ar
	w requires that t been signed by should be detai	ed by Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause gr	ven in Part I.		tobacco use cont Yes 2□No	ibute to the cause of dea 3 Probably 4 □Un	
of Vital Records,	:: The law re icate has be :, page 2 sh								24a. Was auto perf 1 \(\text{Yes}	ormed?/	Vere autopsy findings av prior to completion of caudeath? Yes 2 No	railable ise of
f Vit	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2] ER/Outpatier	it 3□ DOA Ot		of Death (Check only sing Home 5 \sum Res		er (Specify)	
ion o	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ation:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	ation	of Injury nth, Day Year)	28b. Time of Injury	Wo	iry at ork?]Yes 2 □ N		how injury occurr	ed	
Division	tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 28e. Plac build	e of Injury - At I ding, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (City or To	(Street and Numb wn, State)	er or Rural Route Numbe	er,
	To the Hospital or within 24 hours afte To the Funeral Directional Direction of the Funeral Direction of the Puneral Direction of the Funeral Direction of the Funeral Dire	edical	(Check only 2 Medical one)	Examiner: On the	be best of my kn basis of examin nner stated.	owledge, deatl ation and/or in	n occurred at the t vestigation, in my	ime, date and opinion, deatl	d place, and due to the h occurred at the time,	date and place,	and due to the cause(s)	
)	Tot Tot	Σ	29b. Signature and title of certified	All		AG)	29c. Licen	se number 7400 4	4	29d. Date signed	1 (Month, Day, Year) 2, 2004	*
	6		30. Name and address of person	who completed cau	ise of death (Ite	m 23a) (Type,	Print) La Va	le 1	MD 3	1502		
	Sta Registi	- 1	31. Date filed (Month, Day, Year) JUL 1 6 2		Registrar's Sign	ature	Spark	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		•	partment of Hea ertificate of De		Reg. N		221.2
Physicia	an	1. Decedent's Name (First, Middle, Las				Mo	e of Death nth D	Day Year	S. I ime of Death
/Medic	al	Susan Louise Nayl			4b. City, Town, or Loca		ie 26,	4c. County of Death	5:34 A
Examine	er	4a. Facility Name (If not institution, give 9502 Mazzoni Aven	ue		Seabrook		P	rince Geo	
uneral irector		219-64-4316	ex	51 Yrs	Months Davs Ho	ours Min. 8. Dat Feb	e of Birth onth, Day, Yea 27, 1	9. Birth Cour 1953 Mary	place (State or Fore stry) Land
ahow dat	Ļ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or				1	0d. Inside City Lin
Sa-1	Director	Maryland Prince G	eorge	Seabro					
3a or 2 st be n		10e. Street and Number 9502 Mazzoni Aven	ue		10f. Zip Code 20706		10g. (Citizen of What Cour	ntry?
oriant: if item 27 is marked other than "naturel", or Iteme 23a or 28a-1 ehow injury or other traumatic event, the Medical Examinar must be notified at 8.	by Funerai	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	Ever in U.S. 1	Was Decedent of Hispan If Yes, specify Cuban, Mi □ Yes 2X No Sp	nic Origin? (Specify Ye exican, Puerto Rican, o pecify:	s or No- etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
nature solical E	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	(G	cedent's Usual Occupation ive kind of work done during a. DO NOT use retired)	g most of working	16b.	Kind of Business/In	dustry
The M	omp	Elementary/Secondary (0-12)	College (1-4or 5	Proje	ect Support S	Specialist		NASA	
other	BeC	17. Father's Name (First, Middle, Last)			18.	Mother's Name (First,	Middle, Maide	en Sumame)	
is marked or raumatic eve	ToB	Fred Boyd			V	vivian Hips	1ey		
e ma	6 1	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street and N	Number or Rural Route	Number, City	y or Town, State, Zip	Code)
tem 27		Craig Naylor/Husb	and		Mazzoni Aven				
if iter	1	20a. Method of Disposition V Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, c	sposition (Name of crematory or other place)	Date		Location - City or To	
ant:		* 4 □ Donation 5 □ Other (Specify	3	Fort Lin	ncoln Cemeter	- 1		-	-
Important: If item 2 eny injury or other once.		21. Signature of Funeral Section Licen	Aco.		22. Name and Address of B401 Bladensb	urg Rd., B	rentwo	Funeral H	ome 722
		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not	enter the mode of dying, such	ch as cardiac or respir	atory arrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Me-	tastatic	Malianant	44.4	oma	4	Onset and Death
ledical	- 1	resulting in death)	Due to (or as	a consequence of):					
aminer		Sequentially list conditions,	b						
Sit.	ine	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as t	a consequence of):					
and -trans	Examiner	that initiated events resulting in death) Last	C. Due to /or as:	a consequence of):					
	edicai E		d	a consequence or,					
വ വ								22 2	
igned by the attending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 vnorths? 1 ☐ Yes 2 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	nry Day Year
d by		Part II. Other significant conditions o	ontributing to death bu	ut not resulting in the	a underlying cause given in	Part I 23	a. Did tobacco	use contribute to the	e cause of death?
	ed by	Tartin dila significant			and onlying occurrent		1 🗆 Yes		ably 430000
has je 2	Completed					24:	a. Was an autopsy performed?	prior to cor	psy findings availa apletion of cause
certificate harector, page		25. Was case referred to medical					Yes 2	√o 1 ☐ Yes	2 No
recto	o Be	examiner?	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpa	Othor	Place of Death (Check Nursing Home		6 Other (Specific	4
this aldi	tion: To	27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injury at	28d. De	scribe how inj		7
After fune	ig	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			street, factory, office	28f. Loc	ation (Street a or Town, Sta	and Number or Rura ite)	l Route Number,
Director: After	rtiff	4 I Homicide							
Funeral Director: After	ical Certification;	29a. Certifier 1 Certifying Ph	niner: On the basis of	examination and/or	eath occurred at the time, da r investigation, in my opinion				
initize floors are losari. The Funeral Director: After mpletely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam		examination and/or		n, death occurred at the	e time, date a	nd place, and due to	the cause(s)
Funer Funer stely fill		29a. Certifier 1 Certifying Ph	niner: On the basis of	examination and/or	29c. License num	n, death occurred at the	e time, date a		the cause(s)
winin 24 nours after deam. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the basis of and manner sta	examination and/oited.	29c. License nun	n, death occurred at the	e time, date a	nd place, and due to	the cause(s)

			1 - For State Registrar	State of Maryland	d / Depa			Mental Hyg	•	22424		
	Dhysisi	-	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Ye	3. Time of Death		
	Physici /Medi		Cynthia Marilyn	Norvell				06-24-		7:47 p M		
	Examir	ier	4a. Facility Name (If not institution, give				r Location of Death)	4c. County of D			
			Washington Advent 5. Social Security Number 6. Se		at hinth days	Takoma If Under 1 Year	Park If Under 24 Hrs.	0.0	Montg			
	Funeral Director			M 2⊠F 4.		Months Days	Hours Min.	8. Date of Birth (Month, Dey, 08-29-19	9. 958 Po	Birthplece (State or Foreign Country) rtsmouth, Va.		
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show dical Exacting rout the incilitied at		10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits		
	Mar B-f-et	ctor	Maryland Prince (George	Lan	dover				1 X Yes 2 □ No		
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	g. Citizen of What Country?		
	ath w		7774 Burnside Driv			207			U.S.A	Α.		
	er de	Funerai		12. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Pican, etc.)		merican Indian, Vhite, etc.		
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		I□Yes 2X No	Specity:		Specify: I	Black		
21215-0036	be filed within 72 hours after death with the Marylar hal Hygiene. ad other than "naturel", or items 23s or 28s-1 show event, the Medical Exactive frosts by notified at	ed	15. Decedent's Edu		16a. Deced	lent's Usual Occup	ation	1	6b. Kind of Busine	ass/Industry		
215	within 72 ene. than "n	Completed	(Specify only highest grad		(Give life. L	kind of work done of NOT use retired	during most of world)	king	OB. Raile of Beside	Agency		
212	d with giene er tha	mo;	Clementary/Secondary (0°12)	College (1-4or 5+) 5+	Clini	cal Soci	al Worker	:	Anchor M	ental Health		
g	be filed ital Hygir of other event, I	Be	17. Father's Name (First, Middle, Last)	e (First, Middle, M	laiden Sumame)							
<u>la</u>	should be nd Menta marked matic ev	10	Elijah Hayes	/e11								
Maryland	permit. Peges 1 and 2 should Department of Health and Men Mportant: If Item 27 Is marks any injury or other treumatic 2008.		19a. Informant's Name/Relationship (Ty		19b Mailin 2403	g Address (Street :	and Number or Rui Road	ral Route Number,	City or Town, Stat	e, Zip Code)		
	and lealth m 27		Evelyn Joyner/Co		Rich	mond, Vir	ginia, 2	3230				
Baltimore,	Peges 1 ar		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ P			sition (Name of natory or other plac	1	- 3	0c. Location - City			
Ë	permit. Pege Department of Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify)	Roos		Mem. Cer			hesepeak			
Bal	Departiment Depart		21. Signature of Funeral Service Licens	1						ome, Inc. D.C. 20010		
	20200		222 Part Enter the disease or comple	Bacon, ec 34								
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Due to (or as a conseque	ATIC		RAUA			Approximate Interval Between Onset and Death		
	Examiner											
		ner	Sequentially list conditions, if any, leading to annuaciate cause. Enter Underlying	Due to (or as a conseque	ince of).	571 - 1 - 1 - 2						
	ate be executed hysician and he burial-transit	Examiner	that initiated events	b								
,092	e exe ian a urial-	E	resulting in death) Last	Due to (or as a conseque	ence of):							
876	ate b hysic the b	dicai		1								
89 x	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	0. 1/								
Вох	ath cattend	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1☐Live birth 2☐Fetal of	leath 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year		
o.	the a	ysic	1 Yes 2 No 9 Unknown	4☐ Pregnant at time of dea 9☐ Unknown	ath 5	Other (specify)			WORLD	Day Toal		
Ω.	that the solution of the solut	P	Part II. Other significent conditions con	ntributing to death but not result	ting in the un	derlying cause give	en in Part I	23e Did toba	ICCO USA CONTRIBUTE	to the cause of death?		
Vital Records,	sign d be	d by		•		,	on any case is	1 ☐ Yes		Probably 4 Unknown		
200	w requir been si should	Completed										
Re	ricien: The lav certificate has rector, page 2	mp						24a. Was an autopsy	prior 1	autopsy findings available to completion of cause of		
ā		e Co	25. Was case referred to medical					perform 1 ☐ Yes 2				
5		o B	examiner?	lospital: 12 Inpatient 2 E	D/Outpations	3□ DOA Othe		h (Check only one,				
of	Phys ar this eral di	H-1	27. Manner of Death	28a. Date of Injury 2	R/Outpatient 8b. Time of	3 DOA	4 Nursing Ho	me 5 Residen 28d. Describe how		pecify)		
on	Attending I r death. ector: After by the funer	ţ	Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury	28c. Injury Work	(? Yes 2 □ No		milary occurred			
Division	al or Attends after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my knowner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occuri	and due to the cau red at the time, dat	se(s) and manner e and place, and d	as stated. ue to the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1.0		29c. License	number	290	1. Date signed (Mo	onth, Day, Year)		
				MO		00	1715	6.	25.04	ζ.		
/	(25)		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, F	Print) 620/	GREAT	VBELD.	ROAD	U*3		
	Sta		31. Date filed (Month, Day, Year)	. Registrar's Signatu	re	NACO X	MAK	100	140			
	Registr	ar	JUN 2 8 2004	Fleden K	Mary	P.						

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H			iene	221.05
-3	; Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3: Time of Death
	/Medic	al	Woo Jin Oh			Ab Ciby Town o	r Location of Deal		8, 2004 4c. County of De	3:27 A M
- 10	Examin	er	4a. Facility Name (If not institution, give single Suburban Hospit			Bethe				
- 12	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			Mont go	ITTELY inthplace (State or Foreign country)
* . Š	Director		213-03-1322	M 2 F	72 Yrs.	Wortins Days	Hours	Dec. 2	1931 K	orea
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or U	ocation				10d. Inside City Limits
	Maryl -f sho	tor	Korea N/A		Incheo	n City				1 ☐ Yes 2 🙀 No
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Evacinal must be relifted at	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	Country?
	ath wi		Namku Man Su 3				202HO		Korea	- days to diag
	ltems rern	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marned	 Was Decedent End Armed Forces? 1 ☐ Yes 2 ☑ No 	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	14. Race - Arr Black, Wh	
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify: A	sian
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	deni's Usual Occup kind of work done	during most of wa	rking	16b. Kind of Busines	s/Industry
121	within ene. then	ldm	Elementary/Secondary (0-12)	College (1-4or 5+	-)	DO NOT use retired ealtor	d)		Self-Emp	Loved
d 2	Hyginther nt, 1	a)	17. Father's Name (First, Middle, Last)			042002	18. Mother's Na	me (First, Middle, A		ioyeu
<u>a</u>	should be nd Mental merkad matic ev	To B	Bong Eui Oh				Go M	ak Kim		
Maryland	d 2 should be the and Mental I is marked o traumatic eve		19a. Informant's Name/Relationship (Typ						City or Town, State,	
	s 1 and if Health item 27 other tr		Joshua H. Oh -	Son	A STATE OF THE PARTY OF THE PAR	Glennor		Bethesda Date	a, MD 20 20c. Location - City o	0817
nor	0 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disposemetery, cre	matory or other place. Memori		02-2004		
Baltimore,	교육관금 .		21. Signature of Funeral Service License	0 / 1 /			<u> </u>		emorial	•
ä	Depa Impo any i		Petu L. Pise	till	9	902 Brad	ddock R	d. Fair	fax, VA 2	2032 Home
to:			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused t e cause on each line	the death. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Belween Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		osclerot	ic Card	iovascu	lar Dise	ease	Years
	/Medical Examiner			Due to (or as a	consequence of):					
		Jer	Samuentially list conditions if any, leading to immediate cause. Enter Underlying		consequence of).					
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
60,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Ex	resulting in death) cast	Due to (or as a	consequence of):					
68760,	physics the s	edical	- 0							
Box	leath certific attending p	M/U	23b. was decedent pregnant	3c. If yes, outcome of		□Ectopic pregnanc	,		23d. Date of d	
	s death	Physician/Med	in the past 12 months? 1 Yes 2 No	4☐Pregnant at t		Other (specify)			Month	Day Year
P.0	that the de led by the a detached f		9 ☐ Unknown Part II. Other significant conditions con	tributing to death but	t not resulting in the I	ınderiving cause gıv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	uires tha signed d be dei	d by	Tarris of the second of the se		· · · · · · · · · · · · · · · · · · ·					Probably 4 BUnknown
cor	w requir been s should	Completed						24a. Was a	n 24b. Were a	autopsy findings available
Re	The law ate has page 2.9	omp						autops perform	ned? death?	
Vital		Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on		
of V	Physician: this certificaral director, I	To	1 ☐ Yes 2 🔀 No	ospital: 1 Inpatier		III 30 DOA			nce 6 Other (Sp	ecity)
	fe life	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo	ryat rk? ∣Yes 2 ∐No	28d. Describe ho	w injury occurred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, farm, si		1143 2 1140		reet and Number or F	Rural Route Number,
Ö	s after	Certification:	4 Homicide	building, etc.	(Specify)			City or Town	, State)	
	To the Hospital or Attending Physician: Within 24 hours after death. The Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 Cartifying Physic (Check only one) 1 Madicel Examin	ician: To the best of ter: On the basis of and manner stat	examination and/or in	th occurred at the tinvestigation, in my o	me, date and plac opinion, death occ	e, and due to the ca urred at the time, da	tuse(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To the selection of the	Me	29b. Signature and title of certifier	Li, mid		29c. Licens	4550	19	o 6/28/	04
	Chip		30. Name and address of person who co			Print) HA	MATTA V	NICKRAM	MINATE	BETHERA, M
	8		SUBUPBAN 21 Date filed (Month Day Year)	プンパエフ 32. Registra	2,10	, 86 W	7 013	K ENKAL-TE	WN FD,	BETHONEN
	Sta Regist		JUL 0 2 2004	Jese Jese	Lance 1					

		•	For Stete Registrar		ryland / Depa		of He		Mental Hy	/giene	2001	22626	
			Decedent's Name (First, Middle, Las	()					2. Date of D			3. Time of Death	
	- Physicia		Stanley E. Olek						June 2	Day 25. 2	7 Year 004	6:30 a M	
)÷	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, To	wn, or L	ocation of Death			County of Dee		
	Examin	eı	6109 Ruatan Stree			Berw	yn I	Heights		P	Prince George's		
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Months [Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth Day, Year)	9. Bir Co	thplace (State or Foreign puntry)	
	Director		193-12-1415	ĎM 2□F	78 Yrs.	IVIOITATS	Jays	1.00.0	July 2	2, 19	25 Pen	nsylvania	
	p .		Usuel Residence of Decedent		10c. City, Town or Lo	nation						10d. Inside City Limits	
	ahow		10a. State 10b. County									1∭Yes 2□No	
	Ba-f.s	5	Maryland Prince	George's	Berwyn H					10- 0%	izen of What C	- Lintara	
	ith th	Director	10e. Street and Number			10f. Zip C	000	207/0			S.A.	Jurilly	
	23a		6109 Ruatan Stre		110	W Dd-	a al Uia	20740	panty Vac or h		3 • A •	aricen Indian	
	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Il Yes, specify	Cuban,	panic Origin? (S _I , Mexican, Puerto	Rican, etc.)		Black, Whi		
36	or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 N If Yes, Give Year or Dates:		1 ☐ Yes 20	No.	Specity:			Specify:	White	
8	d within 72 hours effer death with the Maryland ilene. Then "natural", or Items 23a or 28a-f show then Medical Examiner must be notified at the Medical Examiner must be notified at	pa	15. Decedent's Ed		16a Dece	dent's Usual (Occupat	ion		18b. K	ind of Business	/Industry	
7	n 72	let	(Specify only highest gra-	de completed)	life.	kind of work DO NOT use	done du retired)	ring most of wor	king				
12	filed withi Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Analy	rst				Fe	deral G	overnment	
Maryland 21215-0036	Hyg Hyg		17. Father's Name (First, Middle, Last)				1	18. Mother's Nan	ne (First, Middi	le, Maiden	Surname)		
lan		To Be	John Oleksak					Viola	Orciucl	n			
<u></u>	E DEE	F	19a. Informant's Name/Relationship (ype, Print)	19b. Maili	ng Address (Street ar	nd Number or Ru	ral Route Num	ber, City o	r Town, State,	Zip Code)	
	d 2 th a		Dorothy Olek - S	pouse	6109	Ruata	an St	treet, B	erwyn I			yland 20740	
ē,	of Health itsm 27 i		20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name	of er place)	Date	20c. Lo	ocation - City or	Town, State	
10			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State /)					3/2004	Alex	kandria	, Virginia	
Baltimore,	artro artruit		21. Signature of Funeral Sporice Licen					of Facility Ga					
B	Depa Impo any i		Van L'Üelue	· les a -	4	739 Ba	ltir	more Ave	., Hyai	ttsví	11e, ML	20781	
9	454		23a. Part1. Enter the disease, or composite hock, or heart failure. List only	olications that caused	the death. Do not en	ter the mode	of dying,	such as cardiac	or respiratory	arrest,		Approximate Interval Between	
			Immediate Cause (Final		Failure							Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	a consequence of):								
	Examiner	Ų.		Hepatic	Metastati	c Dise	ase					Six Months	
	, A. S. L	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	s consequence of):								
	te be executed ysicien and ne burial-transit	Examiner	Cause (Disease or injury that initiated events	Broncog	enic Carci	noma							
ć	exec in an	Exa	resulting in death) Last	Due to (or as	a consequence of):								
760,	e be /sicie e bur	cal		d									
68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Medi					-			1			
Box	n cert andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pre	onancy				23d. Date of de	livery Day Year	
	death e atte	lcla	in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregnant at		Other (spec					Month	Day 1 Bat	
0	that the de ed by the detached	hys	9 Unknown	-									
ď.	ires tha signed I d be det	y P	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	underlying car	use giver	n in Part I.				o the cause of death?	
Records,	quire on sig uld b	ed t							1	Yes 2	∐No 3∐P	robably 4 🕅 Unknown	
000	s been si	ojet							24a. Wt	as an	24b. Were a	utopsy findings available completion of cause of	
Re	The law te has age 2	H _O							per	formed? 2 X No	death?	_	
tal	an:] tifical tor, p	(a)	25. Was case referred to medical					26. Place of Dea					
of Vital	Physician: this certificant all director,	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital:	nt 2 ER/Outpatie	ent 3 DOA	Other	r. 4X Nursing H	fome 5 ☐ Re	sidence	6 ☐Other (Spe	ecify)	
0	g Phy eral (27. Manner of Death	28a. Date of Inju (Month, Da	y Year) 28b. Time	of 28	c. Injury Work	at	28d. Describ	e how inju	ry occurred		
Division	Attending r death. sctor: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		,,	М		es 2 □ No					
Visi	Attendi r death. sctor: A by the fu	III C	3 Suicide 6 Could not b		ury - At home, larm, s	treet, lactory,	office			(Street ar		lural Route Number,	
Ö	afte Dira d in t	Certification;	4 Hotticide	Dulldarg, en	o. (Opechy)								
	To the Hospitel or Attending Physicien: The I cynthin 24 hours after death. To the Funeral Director: After this certificate har completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	nysician: To the best niner: On the basis of	of my knowledge, dea	th occurred a	t the time	e, date and place	, and due to th	e cause(s) and manner a	s stated.	
	na Ho n 24 na Fa	edicai	(Check only 2 Medical Examone)	and manher sta	ated.								
	To the	×	29b. Signature and title of certifier	D. The				number			ite signed (Mon		
	(13))	YMJ-	7]]	12	2910		Ju	NE 28	th, 2004	
	O IV	2	30. Name and address of person who										
	90		Asif S. Quadri,	M.D., 4700	Berwyn Ho	ouse Ro	1., 5	Ste. 100	, Colle	ege P	ark, MD	20740	
	St.	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature								

				State	of Marylar				lealth an <i>Death</i>	d Mental I			da I	
			4 Daniel Name (Final Middle)	41		Cel	liliCa	ile Ui i	Dealli	2. Dete o		3. N6.)) 4-	2 7 7 7
	Physicia	n	1. Decedent's Name (First, Middle, I	.ast)						Month		Dey	Year	5. Hinte of Death
	/Medica	al -	Viduds Ozolins							JUN		-	DOU	1245 PM
	Examine	er	4a Fecility Name (If not institution, g	ive street and n	umber)			4	4b. City, Town,	, or Location of D	Jee(I)	4c. County		
		Q ²	Crescent Cities						River			Princ		
	Funeral			Sex 1XIM 2□ F	7. Age (In yrs		Month	er 1 Year S Days	If Under 24 Hours	Min. (Month	f Birth Day, Y	(eer)	9. Birthp Coun	lace (State or Foreign try)
	Director		579-48-2251	123 101 201	73	Yrs.				Oct.	<u>27,</u>	1930	Latv	ia
	D s	F	Usuel Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation						11	Od. Inside City Limits
	short a	ا ج												1 ∑ Yes 2 □ No
	Ne M	ᇗ	Maryland Prince	George'	s B	ladensh		ip Code			100	g. Citizen of V	What Cour	tn/?
	A P	Director	10e. Street end Number				101. 2	ip Code			100	g. Onizen or v	WHO! COU!	uy:
	ath v	Completed by Funeral	5201 Quincy Stre			10 10	Was Das		20710	2 (C-pails Van a		atvia	e - Americ	an Indian
	er de	š	11, Merital Status	Armed F		7,5.	If Yes, sp	ecify Cuba	an, Mexican, P	? (Specify Yes o Puerto Rican, etc.	.)		k, White,	
20	s eff	5	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	If Yes, C			1 🗆 Yes	2 ⊠ No	Specify:			Specify	" Whi	te
8	urai :	象			Dates.	16e. Dece	dent's Lis	ual Occur	ation		16	6b. Kind of Bu		
5	"nat	e	15. Decedent's (Specify only highest of)	(Give	kind of v	vork done i use retired	during most of	f working	, ,	ob. Telling of De	3011100341110	Lowy
12	withir	티	Elementary/Secondary (0-12)	College	(1-4or 5+)				,		1	B., i 1 d i .	na In	dustry
2	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural, or items 23a or 28e-f show ent, the Medical Examinar must be notified at	ပိ	12 17. Father's Neme (First, Middle, La.	st)		Carpe	HILEI	-	18. Mother's	Name (First, Mi				dustry
an	ntal I be d	Be	Edgars Ozolins	,					Linii	ja Staun				
Ë	should be filed with nd Mental Hygiene. marked other than umatic event, the	၉	19e. Informant's Name/Relationship	(Time Driet)		10h Maili	an Addro	es (Stroot		or Rurel Route N		City or Town	State Zin	Code)
Maryland 21215-0020	O 0 00 00	l	•				•					•		
	Health Health em 27	ŀ	Inara Sturans - 20a. Method of Disposition	Sister	20h					#301, B		oc. Location -		
ō	Pages nent of H		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	n State	Place of Dispo cemetery, crea	matory o	other place	ce)	1			,	
Baltimore,	pemit. Pag Depertment Important: I any Injury o		4 Donation 5 Dother (Spec		Ro	ck Cree				7/1/20				
all	pemit. Depertrimports Imports any Inj.		21. Signature of Funeral Service Lic	ensee		22	2. Name	and Addre	ss of Facility	Gasch's	Fun	eral H	lome,	P.A.
ш	205 20	- 1	Kd rent	1(a	-	4	739	Balt:	imore A	Avenue,	Hyat	ttsvil	le, M	D 20781
6.	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		Cinoma	or es a conse		-	e m.	ethor	27)	7		Approximate Interval Between Onset and Death
	p ii or	a l		• b ———									i	
	cete be exacuted physicien end it the buriel-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	-	Due to (or es a consec	quence o	f):						
8760,	oe ex		Cause (Disease or injury					i						
87	sete the the the the the the the the the	dlcal	that initiated events resulting in death) Last	**	Due to (or as a consec	uence o	f):					!	
9	ing p	<u>₹</u>		■ d									į	
Box	ath co	an l												
	requires that the death certificen signed by the ettending I hould be deteched for use es	Completed by Physiclan/Me	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying	g cause giv	en in Part I.	23b.	Did tob	ecco use col	ntribute to	the cause of death?
P.0	d by	€	Enceshela.	matri							1 🗌 Yes	2 □ N o	3 ☐ Prot	pably 4 Unknown
	es the digner of	2	Encephala. anemia	7									Odb W	are autopou findings
Records,	v require been si should	इ	anemia								Was an perform	autopsy ed?	ava	are autopsy findings ailable prior to mpletion of cause
ပ္မ	e law r hes be ge 2 sh	ᆲ								-				death?
Œ	The law rete hes by	통								3 1	t∐ Yes	215 No	10	Yes 2 No
Vital	an: tiffice ttor, p	Be G	25. Was case referred to medical						26. Place of	Death (Check o	nly one)	-	
>	direction .	2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2] ER/Outpatie	nt 3□	DOA Oth	er: 4 KNursi	ing Home 5 □ I	Residen	ice 6 □Oth	er (Specify	y)
1 of			27. Menner of Death	28e. Det	e of Injury onth, Dey Year)	28b. Time of	f	28c. Injur Wor	y et rk?	28d. Desc	ribe hov	v injury occur	red	
Division	Attending in death.	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	1	,,,	,	M		Yes 2 □ No)				
<u>Vis</u>	Attendil or death. octor: A by the fu	울ㅣ	3 ☐ Suicide 6 ☐ Could not determine	286. Pla	ce of Injury - At I	nome, farm, st	reet, fact	ory, office			on (Stre		er or Rura	l Route Number,
Ö	P effection	ह्र।	4 1 1 10 111 10 10	501	allig, old. (open							,		
	papitu hours inera y fille									place, and due to				
	To the Hospital or Attendil within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exone)		basis of exemin enner stated.	ation end/or in	vestigati	on, in my o	pinion, death	occurred at the ti	ine, dat	e and place,	and due to	uie cause(s)
	within To th	Ž	29b. Signature end title of certifier)	0	2	9c. Licens				d. Date signe		
	(0)		Promele	nler	alu	U		Di	0185	2	1	UNE:	25,	2004
	14/2	-	30. Name end address of person wh			m 23e) (Type,	Print)				1			<u> </u>
			Paul A. DeVore,					ad, H	lyattsv	ille, Ma	ary1	and 20	781-1	435
	Stat	е	31. Date filed (Month, Day, Year)		Registrar's Sign		_							
	D. Carlo		1111 0 Z /UU4 - 1	10.0	1	and I								

DHMH 16 Rev 6/95

٠			1 - For Amend Item #		ardand / Pen Ce	artment of H rtificate of L	ealth and M Death	Reg	g. No.	22428
	Physici		1. Decedent's Name (First, Middle, Last CLARENCE CARL					2. Date of Death Month JULY	8 2004	3. Time of Death 9:02P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number))	4b. City, Town, or	Location of Death		4c. County of Death	
			FREDERICK MEMO			FREDER	ICK	0.0	FREDERI	
	Funeral Director		5. Social Security Number 6. Se 496–14–1833	X DM 2□F 7. AQ	ge (In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) Feb 16,	Ye <i>ar</i>) 9. 8171 1916 Mi	nplace (State or Foreign untry) SSOURI
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	action				10d. Inside City Limits
	Maryla -f ehov fied at	to	Maryland Frederi	.ck		stown				1 ☐ Yes 2X No
	a within 72 hours after death with the Maryland Jiene. r then "naturel", or items 23a or 28a-f ehow The Madical Exaninel must be natified at	Funeral Director	10e. Street and Number 7380 Ira Sears R	oad		10f. Zip Code	2 171 0	10	g. Citizen of What Co	untry?
	death ms 23	neral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.		ispanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
36	irs after ir, or ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Yes 25 If Yes, Give Year or Dates:	[№] 1942– 1946	1 ☐ Yes 2 [X] No		nicall, etc.)	Black, White	hite
2-0	72 hou	eted	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Usual Occupa	turing most of workii	ng 1	6b. Kind of Business/l	ndustry
21215-0036	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 4		DO NOT use retired ctor of G	ov't & Pu	blic	Science H	oundation
land	ild be filed lental Hygir ked other ilc event, ti	o Be C	17. Father's Name (First, Middle, Last) Wilhelm Erdm	an	Ohlke		18. Mother's Name Amanda	(First, Middle, Ma Phoeb		oin
Maryland	ges 1 and 2 should be it of Heelth and Menta it item 27 is marked or other treumatic ev	_	19a. Informant's Name/Relationship (T Frances N. Ohlke			-			City or Town, State, Z n, Marylar	
	s 1 and 3 of Heelth item 27 other tra		20a. Method of Disposition	<u> </u>	20b. Place of Dispo				0c. Location - City or	
altimore,	permit. Pages Department of I Importent: If It any injury or o		1 ☐ Burial 2 ☐ Spremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify)		Smithsbu	rg Cremat	ory 7/10/	04 S	mithsburg,	Maryland
Bal	Depar Depar impor any in	. 3	21. Signature of Funeral Service Licens		M00706	2. Name and Addres Keeney 106 East	& Basford Church St	P.A. Fu Freder	neral Home ick, MD 21	701
	Pnysician		23a. Pan 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each l	d the death. Do not en	ter the mode of dyin	g, such as cardiac o	r respiratory arres	st.	Approximate Interval Between Onset and Death
8760,	/Medical Examiner ohysician and the prinal-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	s a consequence of): s a consequence of): s a consequence of):					
.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P	sigr d be	by	Part II. Other significant conditions co		but not resulting in the t	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	lopsy findings available ompletion of cause of 2 No
Vita	Physicien: T this certificat ral director, pr	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpati	ent 2 ER/Outpatie	Oth	26. Place of Death	The same of the sa) nce 6 □Other (Spec	34.1
on of	ding h. After fune	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 28b. Time o	f 28c. Injun Worl	at 2	28d. Describe how		ny)
Division	f or Attending efter death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st tc. (Specify)	reet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospitel or Atter within 24 hours efter de To the Funeral Directo completely filled in by th	edical C			t of my knowledge, dea of examination and/or in tated.					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7	5-10	29c. License	21944	290	d. Date signed (Month	i, Day, Year)
	10				death (Item 23a) (Type	-		#704	DREST	uck my
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist 1 5 2004	rar's Signature	1/2 Aires	ey ave	2-1	1 1-01-011	aca my
			301	- 4 -401	MARIEN .	A PROPERTY	The second secon			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 28 June 2004 Shirley Muriel Clayton Purvis 4:49a [™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2▼ F Feb. 6, Yrs. 144-20-1509 76 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County en "natural", or iteme 23a or 28a-f show Madical Extrainer must be notified all 1XYes 2 □ No Completed by Funeral Director Prince George Capitol Heights Maryland 10g. Citizen of What Country? 10e. Street and Number United States 4912 Heath Street 20743 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 3 Legal Secretary Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filt Department of Heelth and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event <u>once</u>. Be James Clayton Cora Johnson c 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Purvis/Husband 4912 Heath Street, Capitol Heights, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/29/04 Metropolitan Alexandria, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Servi Licensee Alexander S. Pope Funeral Home 5538 Marlboro Pike, Forestville, MD 20747 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** Assinat disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coun inc Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an rmed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient ٩ 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Diractor: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted eause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 3 0 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yee **Physician** 20 2004 Rosa Lee Phillips June /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery County Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 28, 1940 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days Min 1 □ M 2 및 F 63 Yrs. 139-34-2671 Alabama Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ral', or Itams 23a or 28a-f ehow Exeminer must be notified at 1. Yes 2 □ No Director Prince Georges Mt Rainier Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 3356 Chillum Road #201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3√ Widowed 4 Divorced "natural" Completed the Mudical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) jes 1 and 2 should be filed within i of Health and Mental Hygiene. If Itam 27 Is marked other than "1 or other traumatic event, the Mad Elementary/Secondary (0-12) College (1-4or 5+) Secretary Goverment 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Murray Magrozie Turnipseed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Jacqueline Y.Patrick-Dallas 1720 27th St SE #102 Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permil. Pages 1
Department of H
Important: If Ital
eny injury or oth 1 ☐ Burial 2万 Cremation 3 ☐ Removal from State June 30,04 Arl, VA Metropolitan 5 ☐ Other (Specify) ° 4 □Donation 22. Name and Address of Facility
Joe Baltimore Funeral Home Inc 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fouture. Immediate Cause (Final Respiratory Physician disease or condition resulting in death) /Medical Examiner chamic obstauctive pulmonary disouse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Hy potension inding physician and use as the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, pneumonia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Hinknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 1 Inpalient 3□ DOA 2 28a. Dale of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 52586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Jayanti L. Patel 1500 Forest Glen Rd Silver Spring Md 20910 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM 23b PER PHY G833 7/16/04 Contificate of Death Reg. No. 2. Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) 23,2004 **Physician** June James Phelps 12:10AM Matthew /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Charles County Nursing Home & Rehab La Plata Charles If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 17,1914 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2□ F Maryland 89 217-36-6044 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haallh and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examiner must be notified at once. Newburg 1 ☐ Yes 2 No MD Charles Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20664 14145 Banks O'Dee Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: X Never Merried 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specity: Specify: Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Farmer Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Carrick William Preston Phelps Ester 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
P.O. Box 1241 La Plata, MD 20646 19a. Informant's Name/Relationship (Type, Print) Rebecca Harman/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Oak United Methodist6/28/04 Mitchellville, 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22. AREHARTS ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Respira Examiner RECURRENT ASPIRATION PNEUMONIA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerubra vay unlar Hospital or Attanding Physician: The law raquiras that the death certificate ba Completed by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 No 3 Probabty 4 Unknown fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 ▼ No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth Certification: 5 Pending investigation 1 Naturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my one stated. edical 29a. Certifier (Check only one) ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 6-21-04 D33426 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

B. Larry Jenkins, Jr. M.D. P.O. Box 2665 La Plata, MD 20646 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JUN 2 5 2004 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 29 2004 2:30p M June Russell /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner 2301 Olson Street #202 Prince George Temple Hills If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 1**X** M 2□ F 57 Director 577-62-5151 1946 Oct. 4, South Carolina Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or items 23a or 28a-f ehow other traumatic event, the Madical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Maryland Prince George Temple Hills Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 Olson Street #202 20748 United States by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Iter 1 GYes 2 No 1966
If Yes, Give
Year or Dates: 1968 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: Specify: **Black** 3 Widowed 4 Divorced 1968 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Private 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Rush, Sr. Lula Mae Brand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Olson Street #202, Temple Hills, MD Vickie L. Rush/Spouse 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Resurrection 7/3/04 Clinton, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Alexander, S. Pope Funeral Home 5538 Marlboro Pike, Forestville 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Lung Cancer with Bone Metastases 4 months /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, oulcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Š been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deep Venous Thrombophlebitis 11€ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Clostridium Difficile Colitis 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 24 No 2□ No 1 Tyes 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ဥ 2 ER/Outpatient 3 DOA this Director: After th 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 XNatural 1 □ Yes 2 □ No investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signatur

UA

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)
JUL 0 2 2004 State Registrar

30. Name and address of person who

leted cause of team (Item 23a) (Type, Print)
110 Irving Street, NW Washington, DC David J. Perry, MD 32. Registrar's Signature

18561 - DC

20010

or 28a-f show

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other traumatic event, the Medical Examinary sust be notified at

e filed within 72 hours after death in all Hygiene.
Other than "natural", or Items 23s.

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Baltimore, Maryland 21215-0036

Box 68760 certificate be

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Division of Vital Records.

Hospital or Attending

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 June **Physician** 01:00 SHEPHARD RAGLAND KENNETH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/04/1984 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days XXM 2□ F 20 215-15-4172 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1√ Yes 2 No Director Prince Georges' Landover MD 10f. Zip Code 10g. Citizen of What Country? 0e. Street and Number 20785 U.S.A. 7731 Bender Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 2X No Yes 1 ☐ Yes **X**No Specify: Specify: Black If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supply Clerk Private 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ragland Rufus K. Marbury, Jr. Renee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20785 Renee Ragland-Carroll-Mother 7731 Bender Road; Landover, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Pk. 07/03/2004 Landover, MD. 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Robert O. Freeman Funeral Services, Inc. 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown

Physician /Medical **Examiner**

> the attending physician and hed for use as the burial-transit Physician/Medical signed by t þ Completed certificate has Be 2 Certification:

9 Unknown

Hospital:

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury

24a. Was an autopsy performed Yes 2□No 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2□ No

3 Probably 4 Unknown

26. Place of Death (Check only one) 5 ☐ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 🖟 No

Other: 4 Nursing Home 28d. Describe how injury occurred

16/04 Place of Injury - A building, etc. (Sp Place - At home, farm, street, facury, office 10 6-16 · M

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, St. te) 1600 Fedex 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Si Vatur

5 Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical

1X Yes 2 □ No

examiner

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

29c. License number O.C.M.E.

28c. Injury at Work?

1 TYes

29d. Date signed (Month, Day, Year) June 28, 2004

erson who completed cause of death (Item 23a) (Type, Print) ess of

111 Penn Street, Baltimore, Maryland 21201

State Registrar

JUN 3 0 2004

Date filed (Month, Day, Year)

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OBINSON JUNE 2004 /Medical or Location of Death acility Name (If not institution, give street and number) Examiner Prince GEORGE CHEVERLY GEORGE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day/Year) 3/30//938 5. Social Security Number 226-46-77 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days -46-7798 1 M 2 □ F Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County ral, or itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? OND Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2DINO 21215-0036 1 🗆 Yes þ 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygiene.
7 ie marked other then "natural", traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RUCK Baltimore, Maryland (First, Middle, Last) Be Health and Mental ပ 19b. Mailing Address (Street and Number or Rural Route Number, City permit. Pages 1 and 2 s Department of Health ar Important: If item 27 te any injury or other trau QNCS. JECOND OK 1 ZBurial 2 ☐ Cremation 3 Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W L. Thompson Funeral Home 21. Signature of Funeral Service Licensee Culpeper Approximate Interval Between Onset and Death Physician /Medical **Examiner** FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ACIDOSIS To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit LACTIC Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 ☐ Yes 2X No 2 ER/Outpatient ŧ Medical Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation death. 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -22-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHOLARTZ 3001 HOSPITAL CHEVERLY, MD 20785 STEVEN / JON 31. Date filed (Month, Day, Year)
JUN 2 9 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Mary		artment of H tificate of I			giene Reg. No.2 11 11	1. 221.25
F			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medic		James Robert	t Randolph,	Jr.			June 21	Day Ye 2004	10:03a M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of E	Peeth
			209 Dauntly Stree			Upper M	arlboro II Under 24 Hrs.	10.0		Georges
	Funeral Director		5. Social Security Number 6. Sex	M 2∏F	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt	y, Year)	Birthplace (State or Foreign Country)
	*		577-52-2977 Usuel Residence of Decedent	0	55 Trs.			paren 2.	3, 1939 W	ashington,D.C
	how		10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits
	e Ma Sa-f s	cto	Maryland Prince G	eorges	Upper M	arlboro				1X Yes 2 □ No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	•
	be filed within 72 hours after death with the Maryland at Hygiene. A clother than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, the Medical Evantinar must be notified at		209 Dauntly Street		sin II C 12.1	20774	innania Oninina (Co	- N N-	United S	
	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2∑ Married	12. Was Decedent Eve Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	6/27/56	Was Decedent of Hi I Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, V	American Indian, Vhite, etc.
990	urs af	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 5 /		I□Yes 2½ No	Specify:		Specify:	Black
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occupa	ation	(ina	16b. Kind of Busine	ess/Industry
21	ithin 7.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)	ung		
2	filed wi Hygien other th		12		Со	ntract Of		(C) A (1) A (1)	Govern	nent
and	2 should be filed and Mental Hygi is marked other aumatic event, II	Be	17. Father's Name (First, Middle, Last) James Robert Rand	olph			Martha	e (First, Middle, Clagget	Maiden Sumame)	
Ž	should be that and Mental I americal or umatic even	유	19a. Informant's Name/Relationship (Tv.	-	19b Mailir	n Address /Street a			r, City or Town, Stat	e Zin Coda)
	ith ar 27 is r trau		Violet R. Randolp	·					o, Md. 20	
Baltimore,	s 1 and 2 should if Health and Men item 27 is marke other traumatic		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	al I	Date	20c. Location - City	or Town, State
E	Pages nent of int: If it iry or o		ty Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Veterans		25,2004	Cheltenha	am, Md.
ati	permit. Pages 1 a Department of Hes Important: If Item eny injury or othe		21. Signature of Funeral Service License	99	22	Name and Address Alexander 5538 Mar	s of Facility	Funera	l Homes	
m	80 5 8 9		Trittel Jang	MD1053						1. 20747
# H			23a. Penti. Enter the disease, or complishock, or heart failure. List only on	cations that caused the le cause on each line.	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	METAST	mc (ASIRIC	- CAU	CER		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
B		10	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
	nsit	nine	Cause (Disease or injury	330 (3) (3) 43 4 50	31304001100 01).					
<u>,</u>	n and ial-tra	Examiner	that initiated events cresulting in death) Last	Due to (or as a co	onsequence of):					
68760	ficate be executed physician and st the burial-transit	edical								
		Medi	IE EENALE.				-		1	
Вох	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a	Physician/M	230. Was decedent pregnant	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d. Date of	
0	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Year
<u>Ч</u>	hat th d by detack		Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	daching cauca awa	on in Part I	23e Did to	hacca usa contribut	e to the cause of death?
ds,	ires tha signed t d be det	d by	Turi ottor significant contantions con	inouting to death put in	or resulting in the di	idenying cause give	minirant,	1 ☐ Y		Probably 4 Unknown
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Vital Records,		e Cc	25. Was case referred to medical				00 81	1 ☐ Yes	212 No 1 1 Y	'es 2□No
>	ysician: s certific director,	0 8	examiner?	ospital:	2 ER/Outpatien	3 □ DOA Othe	26. Place of Deat		ence 6 Other (S	ineciár)
0	ding Phys h. After this funeral dir	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury Work	at		ow injury occurred	респу
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Division of	r Atterderies de linecte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (5	At home, larm, stre	et, factory, office		28f. Location (Si City or Town		Rural Route Number,
	ital o									
	To the Hospital or Attending Physician: which a hours after death as a feet death or the Funeral Director. After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1. Certifying Physical Examination (Check only one)	lician: To the best of m	amination and/or inv	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the cred at the time, d	ause(s) and manner ate and place, and o	as stated. fue to the cause(s)
	ithin i	Med	29b. Signature and title of certifier	and manner stated		29c. License			9d. Date signed (Mo	
	+ 3 + 8		Sp. of S	Taol 11	10		8219		06/23	12004
2	15/11		30. Name and address of person who co	mpleted gause of death	(Item 23a) (Type. I				- 4/~	/
	- IVa		1221 Werear	to Lu	Lar	to ULD	2077	14		
		te	31. Date liled (Month, Day, Year)	32. Registrar's						

			1 - State of Maryland / Depar Registrar Certification	ificate of Death	Reg. N	3001 001 00
	Physici	an	Decedent's Name (First, Middle, Last) Michael Roland Repass		2. Date of Death July 7, 20	3. Time of Death 1203 P M
	/Medic Examin			4b. City, Town, or Location of Death	4	c. County of Death
			Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
h	Funeral Director		212-64-0965 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea PIII 16,	1953 MaryTand
	pu 🔭		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation		10d. Inside City Limits
	Manyla f sho	to	M 1- 1 Mantager			1 Yes 2 □ No
	3s or 28s	Funeral Director	10e. Street and Number 9429 Merust Lane	10f. Zip Code 20879	10g. C	itizen of What Country?
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If itam 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic evant, the Medical Evantinative Lodifical at Injury or other traumatic evant, the Medical Evantinative Lodifical at 8.	by Funera	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forcas? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F ☐ Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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land 2	should be filed withind Mental Hygiene. I marked other than matic evant, the Mental Hygiene.	To Be Co	17. Father's Name (First, Middle, Last) Roland George Repass	18. Mother's Name Peggy At	(First, Middle, Maide an Jacobs	en Sumame)
Maryland	and 2 should be lealth and Mental m 27 is marked c har traumatic evi		19a, Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Merust Lane, Gait	Route Number, City thersburg	or Town, State, Zip Code) MD 20879
Baltimore,	permit. Pages 1 ar Department of Hea Important: If itam any Injury or othal		20a. Method of Disposition 14S Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ntion (Name of latory or other place) vet Cemetery July		Location - City or Town, State Frederick, MD
Balti	permit. Pag Department Important: any Injury o		21. Signature of Puneral Service Ucensee M00255	Name and Address of Facility Keeney and Basford 106 East Church St	d PA Funer	cal Home
8760,0	Physician and /Medical Examiner transit the buriar-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	binatus provarions	y acc	
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on of \	hys his	ilon: To	100 = 1	Contract to the	ne 5 Residence 28d. Describe how in	6 ☐Other (Specify) jury occurred
Division	al or Attending P s after death. I Diractor: After t d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, Ite)
	Hospita 4 hours Lunara ely fille	ledical C	29a. Certifier Check only one 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and/or invession 2 Medical Examiner: On the basis of examination and 2 Medical Examiner: On the basis of examination 2 Medical Examiner: On the basis of examination 2 Medical Examiner: On the basis of examination 2 Medical Examiner: On the basis of examiner: On t			
	To tha k within 24 To tha F complete	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	\wedge		Illa	D 11/165	0ND 7	17 7 500 A
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, P	ector Drive	= G+c	un 120514
	St Regist	ate rar		land of		

	,				ggyland/Pea	gatement of Health and National Artificate of Death	lental Hygi	•	201.27
			Decedent's Name (First, Middle, La.	st)	-		2. Date of Death		3. Time of Death
	Physici	an					Month	Day Year	
	/Medic		FLORENCE REBE 4a. Fecility Name (If not institution, giv			4b. City, Town, or Location of Death	JULY	7 2004 4c. County of Dea	12:02 A M
	Examin	er							
			FROSTBURG VILLA			FROSTBURG If Under 1 Year If Under 24 Hrs.	O Data of Dist	ALLEGAN	
	Funeral Director		5. Social Security Number 6. S 213 24 6417 Usuel Residence of Decedent	ex /./ □M 2ĬĀF	Nge (In yrs. last birthday) 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, JULY 29	Year) 9. Bin Co 1921 V	thplace (State or Foreign puntry)
	and and		10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	/any	ō	MARYLAND ALLEGAN	Y	FROSTE	BURG			1 ☐ Yes 2 No
	786-1286-1	Director	10e. Street and Number					077	
	To a	ă				10f. Zip Code	10	g. Citizen of What Co	ountry?
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	tem tem	une	11. Marital Status	12. Was Deceder Armed Forces	5?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	afte or I	by F	1 Never Married 2 Married	1 Tes 2 If Yes, Give	≱N o	1 ☐ Yes 2 ☐ No Specify:		Specify:	white
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5	J within 72 hours after death with the Maryland jiene. I than "natural", or ttema 23a or 28e-f show the Micalcal Examinant he notitied at	ete	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupation skind of work done during most of work	ding 1	6b. Kind of Business	Industry (Industry
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b	be filed tal Hygie d other i	Be	17. Father's Name (First, Middle, Last,			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
/a		၉	JONAS SKID	MORE		ELSIE MA	Y LaRUE		
Maryland 21215-0036	S D E E		19a. Informant's Name/Relationship (Туре, Print)		ng Address (Street and Number or Rui			
	and 2 Balth a n 27 is		ROBERT RIZER / SO	N	114	OLD BLOCHER ROAD,	FROSTBUR	RG, MD 215	32
Baltimore,	- I = =		20a. Method of Disposition		20b. Place of Dispo	maton or other place)		Oc. Location - City or	Town, State
9	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		THE CIME	ERLAND CREMATORY	0/04	CUMBERLAND	MD
₫	- 독립증		21. Signature of Fluneral Service Liger		2	2. Name and Address of Facility			
Ba	permit. Departition of the permit of the per		1 miloull	Varings.)			O W. MAIN	
			23a Part 1 Enter the disease or com	plications that caus		OWERS FUNERAL HOM			Approximate
				^		ter the mode of dying, such as cardiac	or respiratory arres	st,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a RZS	PIRATORY	FRILURE			5 days
	/Medical Examiner		resulting in death)	Due to (or a	a consequence of):	Premonitis			73
	- Addining		Sequentially list conditions,	b. 13	PIRA PION	preunonitis			
	₽ #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or's	s a consequence of):	1			
1	e be executed rsician and e burial-transit	am	that initiated events resulting in death) Last	c					
B	e exe ian a urial-		resulting in death) Last	Due to (or a	is a consequence of):				
37	m 0	Icai	•	d					
68	leath certificat attending phy I for use as the	Jed	IF FEMALE:						
Вох	h ce endi	an/	23b. Was decedent pregnant	23c. If yes, outcom		DEctopic pregnancy		23d. Date of del	ivery
	deal	icis	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 Pregnant	at time of death 5[Other (specify)		Month	Day Year
P.0	The law requires thet the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	9 ☐ Unknown	9□ Unknown					
	es the igned be de	ру Р	Part II. Other significant conditions of	. 1	1 1	inderlying cause given in Part I	23e. Did toba	acco use contribute to	the cause of death?
ĕ	quire n sig ukd b	be	Old Cere	brat I	mfarction	" Gemunlegia	1 ☐ Yes	2 □ No 3 □ Pr	obably 4 2 Unknown
00	w requires been sistemants	Completed	CHRONIC OF	STRUCT	VE Bulen	unary Disea a	24a. Was an	24b. Were au	itopsy findings available
Be	The lay	E	Droseta V	200115			autopsy	ed? prior to death?	completion of cause of
a	icien: Th certificate rector, pag		25. Was case referred to medical	recein	V				2 No
of Vital Records,	ysicien: is certific director,	Be c	examiner?	Hospital:	Since of Service	Other	h (Check only one,		
of	Physical distribution	. To	27. Mannet of Death	1 ☐ Inpa		TI 3 DOA 4 DANUTSING HO	ome 5 ☐ Residen 28d. Describe how	ce 6 Other (Spe	cify)
no	ding Phy h. After this tuneral c	io	1 Natural 5 Pending	(Month, E	Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	Loa. Doscribe non	windary occurred	
isi	death ctor: / the	ca	3 ☐ Suicide 6 ☐ Could not b		njury - At home, farm, st		39f Logation (Stre	not and Number or B	um I Claude Marchae
Division	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	building,	etc. (Specify)	reet, factory, office	City or Town,	eet and Number or Ru State)	irai Houte ivumber,
	pital urs a eral illed		CON CONTROL STOCKET OF						
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director,	Medicai	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	niner: On the basis	of examination and/or in	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	thin thin the	Med	29b. Signature and title of certifier	and manner	stated.	29c. License number	200	d Date signed (Most	h Day Your
	¥ × × 8		800		a. T.	D 2 5/ 20	290	d. Date signed (Mont	, Jay, Tear)
7			1 3 000	my		17-1628		July 1,	1-004
	3		30. Name and address of person who	completed cause of			71-10	K1. 2	5 0 =
				SAMOS		Nav Heorge Creek	Horon	19 Mary Ce	mg21532
	Sta Registi		31. Date filed (Month, Day, Year)	32. Hegis	strar's Signature	/			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Yeer June 29 2004 ANNIE 4:00 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cheverly

If Under 1 Year | If Under 24 Hrs. 3700 62nd Place Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Yrs. 71 Maryland Director 215-30-0179 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Cheverly Directo Prince George's MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code or Items 23e or U.S.A. 20785 3700 62nd Place death v Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black ģ 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Building Engineer Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, I'ma 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Essie Pinkney James R. Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6812 Kipling Parkway District Heights, Maryland 20747 Ann Newsome/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slete 20a. Method of Disposition 1 ☑Buriai 2 ☐ Cremation 3 ☐ Removal from State 7/7/2004 Cheltenham, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran's 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident /Medical Due to (or as a consequence of): **Examiner** Deep Venous Thrombosis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit Pancreatic Cancer the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - AI home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BAMOSTAN 6/30/04 D47604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3048 Mitchellville Road Bowie, Maryland 20716 Sobhan Mathew M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) **0 1** 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Robert Smith 2:00 АМ 26 Λ4 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Takoma PArk Washington Adventist HOspital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, 06 23 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F Director 60 Mississippi 521-58-6811 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic avent, the Macical Examinar must be notified at ★□Yes 2□No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20011 USA #203 Completed by Funeral 5229 4th. St. N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No 1964
If Yes, Give
Year or Dates: 1965 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 1965 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Budget Analyst 2yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Mental item 27 is marked o Annie B. McCoy ို Robert Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1005 Chillum Rd. #209 Hyattsville, MD. 20782 Fannie B. Griffin/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or of 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-2-04 Brentwood, MD. Fort Lincoln 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityMarshall's Funeral Home FP. marshall 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerbovascular accident Physician day. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNA CONCL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by **P** delhale 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Physician: director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М hours after death 2 Accident 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ompletely filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie vithin 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D060330 JUNE 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADVENTIST HOSPITAL, TAKOMA PARK MD. Kegina B. Oslh WASHINGTON 31. Date filed (Month, Day, Year) Registrar's Signature State 3.0 2004 Registrar

JD	Conten		1 - State Registrar	State of Maryland		rtment of Hetificate of L			iene eg. Nó) () () (00110
	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Deat	m CUU4	(3. Time of Death
	Physicia /Medic	al	MARI		SM	LTH 4b. City, Town, or	Location of Dooth	June 21	4c. County of Death	2229Р. м
H	Examin	er	4a. Facility Name (If not institution, give si Prince Georges He			Cheverly			Prince G	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Birth	place (State or Foreign intry)
	Director		579-78-1078 X3	x ^{M 2□F} 46	Yrs.			May 27	, 1958 Wa	ish, D.C.
	yland		10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	8a-fs	ctor	MD Prince Ge	eorges' Mt.	Rai					1 Yes 2 No
	with the or 2	Funeral Director	10e. Street and Number 3607 Perry Stree	a t		10f. Zip Code 2071	12	1	Og. Citizen of What Cou	
	death	nera		2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White	ican Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exat in attribute notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 X No If Yes, Give Year or Dates:		Yes 30 No	Specify:	rrican, etc.)	Specify: B1	
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	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	1	AA T	ildow was		e (First, Middle, I	Priv Maiden Sumame)	ace
ylar	Menta Menta arked atic ev	ТоВ	Robert Jones					ı J. Sm		
Maryland	d 2 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Typ						, City or Town, State, Zi	
	Healt tem 2 other		Elizabeth Scott 20a. Method of Disposition	20b, Plac	ce of Dispos	EMERSON sition (Name of natory or other place		N.E.	Washingt 20c. Location - City or T	on, DC own, State
altimore,	Pages nent of int: If I		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emova: from State	_	d Cemet ϵ		01/04	Washingto	n, D.C.
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License	2	R	Name and Addres	s of Facility Freema	an Fune	ral Servi	ces, Inc.
	7D 2 6 0	_	23a. Part1. Soler the disease, or compile	palions that caused the death.		353 H St	reet. I	V = E : W	ashington	DC 20002
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		ushot b		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequent		uthe b	nes			
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oʻ	an and rial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):					
58760,	icate be executed physician and the burial-transit	edical	Ca							
_		w	IF FEMALE: 23	3c. If yes, outcome of pregnanc	;y				23d. Date of deliv	/ACV
. Box	death certif re attending ad for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de led by the a detached t	Phys	9 🗆 Unknown	9∐ Unknown				an- Diday		
ecords,	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	tributing to death but not resulti	ing in the ur	iderlying cause give	n in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	W
900	aw as b	Completed						24a Was a	y prior to co	opsy findings available ompletion of cause of
<u>س</u>	The sage							1 Yes	med? death? 2 ☐ No 1 AYes	2□ No
Vita	tding Physician: Th th. : Atter this certificate s tuneral director, pa	o Be	25. Was case referred to medical examiner? 1 Types 2 No	ospital:	NOutpatien	t 3 DOA Othe	26. Place of Deat		ence 6 Other (Speci	(64)
J Of	g Phy ter this neral d	n: To	27. Manner of Death		8b. Time of Injury	28c. Injury Work			ow injury occurred	197
sior	Attending r death. sctor: After by the fune	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	6/21/04 :	2210	HAS 101	res 20 No	sily	et that	
Division	of or Attendated after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	0_	City or Town	treet and Number or Runn, State)	Lew the
	Hospita 4 hours Fun ral	edical C	(Check only 2 Medicel Examin	sicien: To the best of my knowledge: On the basis of examination						
	To the I within 2. To the I complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date signed (Month,	Day, Year)
}	F 3 F 8		11/1-1 11 V	3		O.C.	M.E.		June 22, 2	
ID			30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type,	Print) 111 P	enn Stre	et, Balt	imore, Mary	land 21201
1	- 01		THE DOORE M. King 31. Date filed (Month, Day, Year)	A Registrar's Signatur	re 💆				- 110	
	Sta Registi		JUN 2 9 2004	A. Registrar's Signatur	Spe	de				

			State of Maryland / De	partment of Health and Ment	•	4
			_ FOI	ertificate of Death	Reg. No.	04 22441
			Decedent's Name (First, Middle, Last)		ate of Death onth Day	3. Time of Death
	Physici /Medio		George Shearin		25	2004 12:33 FM
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Cou	nty of Death
			University of Maryland	Baltimore, City	(5)	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi	Months Days Hours Min. 8. Days Hours III.	ate of Birth fo <i>nth, Day, Year)</i> 29 1954	9. Birthplace (State or Foreign Country) Washington, DC
	p .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	shov	5				11☑ Yes 2 ☐ No
	Z8a-f	ecto	MD Prince George's G1 10e. Street and Number	enarden 10f. Zip Code	10g Citizen	of What Country?
	with Se or	Funeral Director	8617 Irvin Avenue	20706		
	ms 2;	era	11 Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Specify Y		Race - American Indian,
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortent: If item 27 Is marked other than "natural", or Items 23e or 28e-f show ortent: If item 27 Is marked other than "natural", or Items 25e or 28e-f show injury or other traumatic event, the Mardical Expression matter rolling at a g.	y Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 7 Year or Dates:	If Yes, specify Cuban, Mexican, Puèrto Rican 1 Yes 2 No Specify:	, etc.) E	Black, White, etc. cify: Black
21215-0036	tural al Ex	Completed by	15 Decedent's Education 16a De	cedent's Usual Occupation	16b. Kind of	f Business/Industry
5		piet	(Specify only highest grade completed) (G	ve kind of work done during most of working a. DO NOT use retired)	100.111110	, but it is a second of the se
212	filed within Hygiene. other then "	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12th	Truck Driver	Priva	ite
Þ	othe othe	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	t, Middle, Maiden Sum	name)
<u>la</u>	Menta Menta arked	To E	Unknown	Martha She	earin	
Maryland	2 sho and ls mu			ailing Address (Street and Number or Rural Rou		
2,5	and lealth m 27 her tr			7 Irvin Avenue Glenard		
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importents: If item 27 Is marked other than any injury or other traumatic event, The Managare.		1 22 Burial 2 Cremation 3 Chemoval from State	rematory or other place)		on - City or Town, State
ţi	it. Partmer rtmer rtent: njury		' 4 □ Donation 5 □ Other (Specify) Harmon 21. Signature of Funeral Service Licensee	y Cemetery 7/03/20		ver,Maryland
Ba	Depa Impo			22. Name and Address of Facility J. B. 7474 Landover Road Lar	dover, Mar	yland 20785
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or resp	piratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
п	LXammer	Ļ	Sequentially list conditions, if any, leading to immediate b. A reading to immediate b. Due t (or as consequence of):			
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00	D 70	olete		2	4a. Was an 24	Were autopsy findings available prior to completion of cause of
Re	0 - 0	Completed		1	autopsy performed? Yes 22 No	prior to completion of cause of death? 1 Yes 2 No
ita	ician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Che		
f V	y s	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpa		5 ☐ Residence 6 ☐ 0	Other (Specify)
0	frec		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju	y Work?	Describe how injury occ	curred
sio	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	posting (Street and Mu	mber or Rural Route Number,
Division of Vital Records,	al or Al	Certification;	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	cation (Street and No	mber of Aural Adulte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not be a consistent of the basis of examination and/of and manner stated.	eath occurred at the time, date and place, and di r investigation, in my opinion, death occurred at	ue to the cause(s) and the time, date and plac	manner as stated. be, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date sig	ned (Month, Day, Year)
			Spenon	P16489	061	125/2004
1)_	-(in)		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		
	(10)		Jenniter DeMore MD	22. J. Greene	Baltimore	mb21201
	Sta Regist	ate rar	JUN 3 0 2004 Selection of the state of the s	arle		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** JUNE 20, 2004 11:45A CHERYL E. SMITH /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGES 15404 CEDAR DRIVE ACCOKEEK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2XXF Yrs. ALABAMA 1959 45 04, Director 578 86 6366 Usual Residence of Decedent the Manyland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f ahow the Medical Examiner must be notified at XX Yes 2 No MARYLAND | PRINCE GEORGES ACCOKEEK Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number With Itama 23a UNITED STATES 15404 CEDAR DRIVE 20607 death v Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or ita any injury or other treumatic event, the Medical Examina. 1 Never Married XX Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK Yes, Give 'ear or Dates: Ď 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR- BARBER/STYLIST PRIVATE 1YR. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARIAN HARVEY JOE LEE FERRELL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15404 CEDAR DRIVE ACCOKEEK, MD 20607 MARIAN FERRELL / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 25 JUNE 2004 SUITLAND, MD * 4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 21. Signature of Funeral Service Licer 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC.
4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician LIVER CIRRHOSIS resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year Month Day jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the should be detached o 9 Unknown 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes XX No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: director. 26. Place of Death. Check on one 25. Was case referred to medical Be Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5XXResidence 6 Other (Specify) Certification: To 1 ☐ Yes XX No this 28c. Injury at Work? 28d. Describe how injury occurred uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Division Injury XX Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident by the f after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D45471 JUNE 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 214 SILVER SPRING, MD 20910 1111 SPRING ST. DR. NEGUSSIE Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2004

DHMH 17 Rev 1/2001

Registrar

			State of Maryla		irtment of H <i>tificate of L</i>				
			Registrar 1. Decedent's Name (First, Middle, Last)	Oei	incate of t	Jean	2. Date of Death	g. No:2	3. Time of Death
	Physicia /Medic		Esther H. Str	ub			June	26,2004	
,	Examin		4a. Facility Name (If not institution, give street and number) National Lutheran Home		2.	Location of Death	-	4c. County of Dea	
	5	-		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
	Funeral Director		140-09-7387 1□M 2XF 94	Yrs.	Months Days	Hours Min.	Feb. 5, 1	910 New	Jersey
bd			Usual Residence of Decedent	City, Town or Lo	aation				10d. Inside City Limits
arylar a	shov	ō	Md. Montgomery		ockville	9			1X Yes 2 □ No
the N	28a-1	rect	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	Country?
. I Z 13-UU30 within 72 hours after death with the Maryland	23a or	Funeral Director	9701- Veirs Dr.,		208	350		USA	
r dea	sms if III	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
o affe	o la	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺ No If Yes, Give 3 ሺ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 🛣 No	Specify:		Specify: W	hite
-003	atural E E	edt	15. Decedent's Education	16a, Deced	dent's Usual Occup	ation during most of work	10	6b. Kind of Busines	s/Industry
0 - 14 5 - 15	Madi Madi	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired	during most of work ()		F	_
7	Agiene	Completed	12	CT	erical			Insuranc	e
	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) Fred Haerle				e (First, Middle, Mi Rottman	aiden Sumame)	
	nd Me mark matic	ှင	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
S 43	alth ar 127 Is er trau	,	Rev.Dr.Richard Reichard-E	xecuto:	r-9701-	Veirs Di	., Rock	kville,M	d.20850
ore,	of He of He of other	1	20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	. Place of Dispo cemetery, crem	sition (Name of natory or other place	erddna 6	Date 26	Oc. Location - City o	r Town, State nville, Md.
	tment tant:		4 Donation 5 Dotner (Specify)					Daviuso.	mviiie,na.
Balt	Depar Impor any in		21. Signature of Funeral Selvici Licensee	22		ss of Facility 19 CO., I		lash.,DC	
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate
Þ	hysician		shock, or heart failure. List only one cause on each line.	len co	adie.	do	er		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a cons	equence of):		cles			1 mm gener
Ε	xaminer		hou acas		infact				Incel
7	Sit	iner	cause. Enter Underlying	equence of):	4				years
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S/6U,	physician and the burial-transit	dical	d						
20 10		ledi	15-5-11-5						
. BOX to	tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ F	etal death 3	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
. S	been signed by the attending should be detached for use a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	fdeath 5□	Other (specify)				,
<u>.</u> į	ed by detac	/ Ph	Part II. Other significant conditions contributing to death but not	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ds,	sign ld be	d by	Valvular heart d	isea (50		1 ☐ Yes	3 2 □ No 3 □ F	Probably 4 Unknown
Vital Records, P.O	900	Completed	Aremia				24a. Was an autopsy	24b. Were a	autopsy findings available
¥ 1	nis certificate has director, page 2	E O					perform		completion of cause of
129	artifica actor,	Be C	25. Was case referred to medical examiner?				h (Check only one)	
of Vita	= 6	မှ	1 ☐ Yes 2 1 ☐ Inpatient 2	ER/Outpatier	TT	41X Nursing Ho	ome 5 Residen	nce 6 Other (Sp	ecify)
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	ours after laral Direction by	Certification;	4 Homicide determined building, etc. (Spe	ecify)			City or Town,	State)	
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	(2)		30. Name an address of person who completed cause of death (I	tem 23a) (Type,	-			1177-1177	,
	(J)		SAMUEL G. MALL	ER MI	2-9701 <u>-</u>	Veirs D	r.,Rocky	ville,Md	.20850
	Sta Regista		31. Date filed (Month, Day, Year) JUN 2 8 2004	gnature	160				

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isian	1. Decedent's Neme	e (First, Midd	fle, Last)							2. Dete of De Month		Year	3. Tir	ime of Death
Physician /Medical		Verno	on Kessle	r_Shank	٤					July	9	2004		200
Examiner	4a Fecility Neme (If			number)				4b. City, Tow	wn, or Lor	ocation of Death		unty of Deet	eth	
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Funeral	5. Social Security Nu		6. Sex 1)∑ M 2 ☐ F	7. Age (In yr. 93			ths Days		24 Hrs. Min.	(Month, De	rth ey, Yeer)			Stete or Foreign
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show id at	10a. State	10b. County	y	10c. f	City, Town	or Location							10d. Insi	side City Limits
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or 28	10e. Street end Num						Zip Code				10g. Citizen	of What Co	ountry?	
be filed within 72 hours efter death with the Maryland tal Hygiene. d other than "natural" or thems 23e or 28e-4 show event, the Madical Examinar must be notified at Be Completed by Funeral Director	8832 Wa.	lther_	Boulevard		_	_ 2	21234				Uni	ted St	tates	Ξ
une une	11. Marital Status		12. Wes De Armed	ecedent Ever in Forces? WO1	บร.				gin? (Spe Puerto	ecify Yes or No Rican, etc.)		Race - Ame Black, White	erican India	
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	23a. Part1. Enter th	ne diseese, o	or complications that at only one cause on	it caused the de								l'iar y -	Approx	ximate
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Examiner	resulting in death)		a	Due to	(or as a cc	onsequence o				7		1		
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To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Director: After this cardificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1	1 Ttifyin	ng Physician: To the	ne best of my kr	nowledge, c	death occurre	ed at the tin	me, date and	I place, a	and due to the	cause(s) and	manner as	stated.	.,
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State Registrar	31. Dete filed (Month	1, Day, rear,	6 2004	Registrar's Sign	ieture	4	lan	01	4					

DHMH 16 Rev 6/95

TIME OF DEATH ISN

VERNON SHANK

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

ORIGINAL

ician	1.0	1. Decedent's Name (First, Middle, La				, o. 20a	2. Date of Dea	ath	Year	3. Time of Dea
dica	1	margaret	Sulli	van						7:09
niner	٠ .	ta. Facility Name (If not institution, gi				Fown, or Location of Deat	tn		ity of Death	
le le	_	3090 MINNIE D 5. Social Security Number 6.		(In yrs. last birt		ANCHESTER 1 Year If Under 24 Hrs	8. Date of Birt	h	ARROL 9. Birthp	lace (State or For
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,,	-	Usual Residence of Decedent	AA	00			IMAI J			
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5	000	MARYLAND CAR	ROLL	M	MANCHES'	TER				1 X Xes 2
Oire	=	10e. Street and Number 3090 MINNIE DR	IVE		10f. Zip	21102		10g. Citizen o	of What Cour ED ST	-
o Lo	era	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Deced	ent of Hispanic Origin? (Stry Cuban, Mexican, Puer	Specify Yes or No-		ace - Americ	
ū	בֿ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X Xo If Yes, Give		1 Yes 2		to rican, etc./			
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		19a. Informant's Name/Relationship				(Street and Number or R				_
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Ť		20a. Method of Disposition 1√C/Burial 2 ☐ Cremation 3	☐Removal from State	cemeter	ry, crematory or of	ther place)				
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once.		21. Signature of Funeral Service Lice	egsee			d Address of Facility DURBORAW FUI	VERAL HOM	Æ. P.A	١.	
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in i		Immediate Cause (Final	y one cause on each line),		e of dying, such as cardia	c or respiratory a	rrest,		Approximate Interval Betwee Onset and Dea
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 06, 2004 10:20a HOWARD L. SPENCER, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner UNIVERSITY HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X**M 2□ F MARCH 17, 37 213-96-5998 1967 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director CARROLL WESTMINSTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code OLD MANCHESTER ROAD 1020 21157 U.S.A Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 - Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MECHANIC AUTOMOBILE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOWARD L. SPENCER, SR. NANCY KENNEDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21157 PATHER 1020 OLD MANCHESTER RD WESTMINSTER, 20b. Place of Disposition (Name of cemetery, crematory or other place) HOWARD L. SPENCER, SR. 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State Commetery, crematory or other place)
4 Donation 5 Other (Specify)

Commetery, crematory or other place)
4 Donation 5 Other (Specify) 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens M01191 21157 Approximate Interval Between Onset and Death WESTMINSTER, MD 91 WILLIS ST. 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. would Immediate Cause (Final disease or condition resulting in death) to the aus ce of) Due to (or as a consect Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ⇒Yes 2 □ No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) exam.... 1X Yes Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 7-6-04 1 Yes 2 No 9:09 A M 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 1020 March 1881 Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

burial-transit the attending physician as the Division of Vital Records. P.O. Box use ō To the Hospital or Attending death. Diractor 24 hours a within 2 To tha

29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Wastminster, MD Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and little of

29c. License number OCME

29d. Date signed (Month, Day, Year) 07, 2004 JULY

who completed cause of death (Item 23a) (Type, Print) 30. Name and address

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUL 1 5 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** ROY SCOTT SCHRUM 2004 9:10P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Adonths | Days | Hours | Min. | (Month, Day, Year)

APR 1, 1956 FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 171–46–4236 48 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2√ No Funeral Director MD Washington Cascade 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 14335-A Royer Road 21719 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced neturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 12 Construction of Health and Mental Hygie litem 27 Is marked other t r other treumetic event, 🖺 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald D. Schrum, Sr. Yvonne M. Botterbusch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liesa L. Schrum wife 14335-A Royer RD Cascade, MD 21719 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumber Land Valley 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
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once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jul 10, 2004 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) Crematorium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro, PA 17268 eaute 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bleedin CIZ /Medical Due to (or as a consequence of): **Examiner** tound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed 309 melanong by the attending physician and ached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: If yes, outcome of pregnancy
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2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D14626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (765c 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JUL 1 5 2004 Registrar

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KELVIN	L. THO	MAS	For	State	e of Ma	arylar		-		lealth and I	Mental Hy	400 400			
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	/Medic Examin		4a. Facility Name (If not instituti 1200 JOPLIN	-	d number)					r Location of Death	า		nty of Death		
	Funeral Director		5. Social Security Number 225–98–4843	6. Sex 1 ₩ M 2□		e (In yrs. 44	last birthda Yrs.	Month:	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Day, Year) 1960	9. Birth Cou VI	place (State of intry) RGINIA	r Foreign
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, P.O.	res that the de signed by the a be detached t	by Ph	Part II. Other significant cond	tions contributing	to death b	but not re	sulting in the	e underlying	j cause giv	ren in Part I.	23a. Did	tobacco use co	intribute to	the cause of o	leath?
ords	w require been sig should b										1	Yes 2200	3 Pro	bably 4 🗍	Jnknown
Division of Vital Records,		Completed									24a. Wa auto per 1 Kres	opsy formed?	prior to co death?	topsy findings ompletion of c 2 \(\textit{\text{No}}\)	available ause of
Vita Vita	Phyeicien: this certificated ral director.	Be	25. Was case referred to medi examiner?	Haspitals					Oth	26. Place of Dea				1.	
ţ	hy this al di	n: To	1 X Yes 2 No 27. Manner of Death	28a. [1 ☐ Inpati Date of Inju (Month, Da		28b. Time		28c. Injur Wor	4 Industry		how injury occ	urred	ity) AT S	JENE
ion	ending sath. or: Afte	atio	Z L Modidoni	stigation Fou	dolz	0/04	Z;3	š AM		Yes 2 No	Decea	reel s	Lest		
Sivis	or Atte	ertification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 28e. F	Place of In building, e			street, facto	ory, office		City or To	(Street and Nur own, State) 12	00Ja	plin S	ber,
	within 24 hours after death. To the Funerel Director: After this certific completely tilled in by the funeral director.	edical Ce		el Exeminer: On t		t of my kn				me, date and place	and due to the		mann <i>e</i> r as		a)
_	To the within ?	Mec	29b. Signature and little of certi	er/	11	1		2	9c. Licens			29d. Date sign			
	AC.		MI	Aux	VV	1			0.0	.M.E		JUNE	26,	2004	
	(1)		30. Name and address of person		cause of	death (Ite	m 23a) (Tyl 111 Po	pe, Print) enn S i	treet	, Baltim	ore, Ma	ryland :	21201		
	Sta Registi		31. Date filed (Month, Day, Ye)		32. Regit	rar's Sig	atwo	•					-		

		1 - For State Registrar	State of Ma		artment of H			iene •g. No,2 () {	04 22450
Physic	ian	Decedent's Name (First, Middle, L.	ast) Dee Lafayet	tte Taylo)r		2. Date of Dea Month	Day	Year O. 20 P. M.
/Med	ical	4a. Facility Name (If not institution, gi		ccc rayio		Location of Death	June 2	5, 2004 4c. County	9:30 P. M
Exami	ner	Mariner Health		pring	1	ver Spri			tgomery
Funeral Director		5. Social Security Number 6. 577–18–7823	Sex 7. Age	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day August	Year) 18,1918	Birthplace (State or Foreign Country) Virginia
land wc		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits
Mary a-f ah	iç	Maryland Montgo	omery	Si	ilver Spri	ng			1X Yes 2 □ No
or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	
eath v	Funeral Director	901 Arcola Ave	12. Was Decedent E	ver in U.S. 13.	2090 Was Decedent of Hi		pecify Yes or No-		States - American Indian,
DESIGNATION PARTY STATES AND A	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	° 1944 –	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerti Specify:	Rican, etc.)	Specify.	k, White, etc. Black
2 hours		15. Decedent's l	Education	16a, Dec	edent's Usual Occupa	ation	kina	16b. Kind of Bu	siness/Industry
J within 7 jiene.	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5-	+)	e kind of work done of DO NOT use retired 1to Mechan			Capitol	Cadillac Co.
d be filed antal Hyg ced othe c event,	Be	17. Father's Name (First, Middle, Las Moses Taylo				18. Mother's Nan	ne (First, Middle, Ann H		θ)
should Mail Mark	To	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street a				State, Zip Code)
Mich Shand 2 shall hand 2 shand 2 shand 2 shand all hand a sha		Janice Elaine Po	owell (Daug	hter) 490	00 - 8th S	treet,N.	E.;Washi	ngton,D	. C. 20017
of He or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Disp cemetery, cri	oosition (Name of ematory or other place	July	2,2004	20c. Location -	City or Town, State
DESIGNATION OF COMMITTEE PAGES 1: 2 Department of He mportant: If iten any injury or oth once.		* 4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic	cify)		Memorial	Cemeter	у		d, Maryland
Dermi Depa Impo		> Command	Chow	′ ′	R. N. Hor 600 Kenne	ton Comp	any Mort	icians, Mashingt	on,D.C. 20011
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the death. Do not en e.	nter the mode of dyin-	g, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Septic						one week
Examiner				consequence of): con's Dis	ease				Years
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0	a consequence of):					
bu, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
	calE		d	,					
OC Lifticate by phy as the			- U.						
COTGS, P.O. BOX 68/ wrequires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal death 3	☐Ectopic pregnancy	` <u></u>		23d. Date Mor	e of delivery nth Day Year
	hys	9 Unknown	9□ Unknown						
ecords, P.O. law requires that the as been signed by th 2 should be detache	b	Part II. Other significent conditions Cachexia	contributing to death bu	ut not resulting in the	underlying cause give	en in Part I.			ribute to the causa of death? 3 ☐ Probably 4 ☐ Unknown
requi	Completed	Cachexia							Were autopsy findings available
The law requir ate has been si page 2 should	dmo			· · · · · · · · · · · · · · · · · · ·			24a. Was a autop perfor	sy p med? d	prior to completion of cause of death?
_ = = =	a	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or		Yes 2 No
_ > 0	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatie			A Avursing H	lome 5 Resid		
Ing P		27. Manner of Death 1 ⚠Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	Wor	yat k? Yes 2 □No	28d. Describe h	ow injury occurre	ed
DIVISION I or Attending after death. Director: After	ficat	2 Accident investigat 3 Suicide 6 Could not determine	be 28e. Place of Inju	rry - At home, farm, s		163 2 140			er or Rural Route Number,
DIVISION OI spital or Attending Ph ours after death. serel Director: After th filled in by the funeral	Certification:	4 Homicide	building, etc	c. (Specify)	•		City or Tow	n, State)	
ely Table	edical (29a. Certifier 1 Certifying 1 Check only 2 Medical Ex	Physicien: To the best of aminer: On the basis of and manner sta	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	and due to the dirred at the time, o	ause(s) and ma late and place, a	nner as stated. and due to the cause(s)
To the within 2 To the Complet	Me	29b. Signature and title of certifier	_		29c. Licens		2	_	d (Month, Day, Year)
(2)		Mester	Day &	(N)		8944			8,2004
de		30. Name and address of person wh	shargel, M.			Farragutington, N	-	2nd F1 20895	.oor
S	tate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	кенз	LUBCOH, P	wr A Tand	20073	
Regis		JUL 0 1 2004	Sean &	Sporte					
DHMH 17 Rev 1	/2001								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** June 23, 4:10 P. M Katherine Lucille Lewis Tibbs 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 23, 1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Washington, D. C 1 ☐ M 2 🗙 F 62 Yrs 579-56-5597 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 7 is marked other than "natural", or Itams 23e or 28e-f show traumetic event, the Mydical Examples investigation 1 X Yes 2 □ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 United States 2328 Sun Valley Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after ☐Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: Specify: Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within ; th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) Coltege (1-4or 5+) **Nursing Assistant** U.S.Soldier's Home llth grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Overhal1 Lewis Ethe1 Lee Henry James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant; If itam 27 is Shann Renee Tibbs (Daughter) 2328 Sun Valley Circle; Silver Spring, Maryland othar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important; If it eny injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State July 1,2004 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 21. Signatyre of Funeral Service Licenses 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc. anana 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Security Security) that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 2 No 3 Probably 4 Unknown Sepsis; Scleroderma; End Stage Renal Failure 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 X Yes certificate 2 No or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 XNatural Injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 THomicide Hospital within 24 hours a filled 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36252 NNE 78, 700H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -, MD. 11501 GOORGIA-AVE HSIS WHOTON MD 20902 T. KARIYA 31. Date filed (Month, Day, Year) 32. Registrar's Signatur 0 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For		State of	f Maryla			f Health and N	Mental Hy	giene		
			1 - State Registrar				C	ertificate d	of Death		Reg. No.	nni.	221.52
	Physici		Decedent's Name (First, Middle, Las Victor R	•	1or				2. Date of De Month June	Day 28,	Yeer 2004	3. Time of Deathr
Lorenza de la companya della companya della companya de la companya de la companya della company	/Medic		4a. Facility Name (If n	ot institution, give	street and nur	nber)		4b. City, Tow	n, or Location of Death			unty of Death	1.134
	** Examin	er	Joseph Ric	_		,			imore			,	
	Funeral		5. Social Security Num			7. Age (In y	rs. last birthda	y) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Bir	th	9. Birthpl	ace (State or Foreign
	Director		220-32-782	21	X M 2□F		67 Yrs.	Months Da	ys Hours Min.	Nov. 29	193	6 Mary	Iand
	ס		Usual Residence of D	ecedent									
	rylan how			10b. County		10c.	City, Town or					10	Od. Inside City Limits
	e-fe	cto	Maryland	Prince G	eorge		Upper	Marlbon	ro 				1.X Yes 2 No
	or 28	Director	10e. Street and Numb	er				10f. Zip Cod			•	of What Coun	•
	th will	ai	12800 P	emberton	Court				20774		Unite	d State	S
	dea	ner	11. Marital Status		12. Was Dece Armed Fo	dent Ever in	n U.S. 1	3. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.))- 14.	Race - America Black, White, e	
စ္က	afte or it	7	1 Never Married		1 ☑ Yes If Yes, Giv	2 □ No re 9/1	2/63	1 ☐ Yes 2 🏻					lack
21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f ehow Acal Examinar must be notified at	Completed by Funeral	3 Widowed 4			ates: 7							
/ <u>ry</u>	net	ete	(Specify	 Decedent's Ed only highest gra 	ucation de completed)		16a. De	cedent's Usual Oc ve kind of work do	ccupation one during most of wor stired)	king	16b. Kind	of Business/Ind	ustry
7 2	withir ane. than	ם	Elementary/Second	lary (0-12)	College (1	-4or 5+)	I .	tro Bus (Tra	nsporta	tion
11/50	Hygie Ther nt,	ပိ	17. Father's Name (Fi	irst. Middle. Last)	<u> </u>		rie	LIU DUB V	18. Mother's Nam	ne (First, Middle			CIOII
and and	d be antal	o Be	Edward J						Victoria			,	
~ 5	hould Me mark mati	ဥ	19a. Informant's Nam		voe. Print)		19b. Ma	uling Address (Str	reet and Number or Ru			own. State. Zio	Code)
/ Mary	id 2 s ith an 27 is treu		Thelma Be	, -	• • • • • • • • • • • • • • • • • • • •	pouse	3	-	rton Ct., I		-		20774
	permit. Pages 1 and 2 should be titled within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: If item 27 is marked other than "neturel; or liems 23a or 28e-1 ehow eny injury or other treumatic event, the Madical Examiner must be notified at once.		20a. Method of Dispos					sposition (Name o rematory or other	f	Date	20c. Locat	ion - City or To	wn, State
AS (O+ Baltimore,	ages int of t: If if		1 ⊠ Burial 2 □ `4 □ Donation 5			State			• Park July	1 2004	Salic	bury, M	m
≫ <u>≒</u>	artme artme orteni injury		21. Signature of Fune			1 4	reen A						
	Department of the permanent of the perma		> Qua	2).	1/1	Kel		5538 M	ddress of Facility Po arlboro Pil	ke; Fore	stvil	le, MD.	20747
9	- I		23a. Part1. Enter the shock, or heart	disease, or comp failure. List only	olications that cone cause on e	aused the d	leath. Do not	enter the mode of	dying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Fi	inal		eirrh	osis						Onset and Death MUN + DS
	/Medical		resulting in death)		Due to		sequence of):						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Examiner		Sequentially list cond	litions.	b								
	p #	iner	Sequentially list cond if any, leading to imm cause. Enter Underly that initiated events	ediate ving	Due to	or as a cons	sequence of):						
	n certificate be executed anding physician and use as the burial-transit	Examiner	that initiated events resulting in death) La	st	c	or an a con-	sequence of):						
₹ 99	cian cian	Ē	, ,		Due to t	or as a con-	sequence or,						
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-5°	certifii Iding p	/Me	IF FEMALE:		23c. If yes, out	come of pre	unancy					Dan Arten	
14 %	ath certif attending for use a	by Physician/M	23b. Was decedent p in the past 12 m	onths?	1☐Live b	irth 2 F	etal death	3 □Ectopic pregna 5 □ Other (specif)			230	. Date of deliver Month	ny Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ i 9 ☐ Unknown	No	9☐ Unkn		or death	o ⊡ Other (s <i>pecif</i>)	//				
٠ ح.	that the de ed by the detached	P.	Part II. Other signific	ant conditions of	ontributing to de	eath but not	resulting in the	underlying cause	given in Part I.	23e. Did	obacco use	contribute to the	e cause of death?
ds,	The law requires that the death tte has been signed by the atter bage 2 should be detached for u		- 15	betes	3		•	, ,	•	10	Yes 2□N	io 3 □ Proba	ably 4 Onknown
3 5	v requires been sign should be	Completed						-		24a. Was	20 2	Ah Wara auton	icy findings available
% % 9	has has	m l								auto		prior to com	sy findings available apletion of cause of
1 2										1 ☐ Yes	210 No	1 ☐ Yes	212 No
√ Z	Attending Physicien: r death. ector: After this certific. by the funeral director,	Be c	25. Was case referred examiner?		Hospital:				Other:				Therena
20	Phys rathis	5. To	1 ☐ Yes 2 12 No.	0	1 111		2 ER/Outpat		4 Nursing H	ome 5 Resi	-	Other (Specify,	Hospice
+ 5	tending leath. tor: After the funer	tion	1 Natural	5 Pending investigation		of Injury th, Day Year	r) Injur		Injury at Work? 1 ☐ Yes 2 ☐ No		,,		
يَّةِ ل	death ctor: ,	lica	2 🗋 Accident 3 🗎 Suicide	6 Could not be		of Injury - A	At home, farm.	street, factory, off		28f. Location (Street and N	umber or Rural	Route Number,
< à	lor A after Dire Jin b	Certification;	4 🗌 Homicide	determined		ng, etc. (Sp		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To			
7	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1	Certifying Ph	ysicien: To the	best of my	knowledge, de	eath occurred at th	e time, date and place	, and due to the	cause(s) an	d manner as sta	ated.
	the Ho nin 24 h the Fu npletely	Medical	(Check only 2 one)	☐ Medicel Exen	iner: On the ba	asis of exan ner stated.	nination and/or	investigation, in n	ny opinion, death occu	rred at the time,	date and pla	ice, and due to	the cause(s)
_	To th withir To th comp	Me	29b. Signature and tit	tle of certifier				29c. Lic	ense number		29d. Date s	igned (Month, D	Pay, Year)
			1 2	USO M	P			1	24170		June	228.0	2004
. 0	(5) 11		30. Name and addres	s of person who	completed caus	e of death (Item 23a) (Typ	pe. Print)	- , , , -		/	0310	
('K	1/0		ETSO	MD	Riche	y Ho	spice	838 N.C	24170 Entaw ST	Bali	Fimor	e MI	21201
	Sta Registi		31. Date filed (Month)		82. F	egistrar's Si	ignature						
40	. negisti	al	7014	U U LUUT		W A	T ATOM						

State of Maryland / Department of Health and Mental Hygiene -For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2004 June 16, **Physician** Bervella Cedora Turner 9:40 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Peartree House Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F Days 577-28-4295 Director 21, 91 1912 Pennsylvania Ju1y Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23s or 28s-1 show the Medical Examinar must be notified at 10d. Inside City Limits Maryland Prince Georges West Hyattsville t√ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3114 Kimberly Road 20782 United States America Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: White Completed by Specify: 3x Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Owned Home es 1 and 2 should be filed of Health and Mental Hygier filem 27 is marked other of other fraumatic event, in other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Henderson 2 Catherine Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Isn any injury or other traun Robert W. Turner/Son 223 Venta Dr. Ocean View Delaware 19970 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funcing Service Licensee Fort Lincoln Cemetery 6/19/2004 Brentwood, Maryland 22. Name and Address of Facility
Fort Lincoln Funeral Home
3401 Bladensburg Road Brentwood, Maryland 20722 once. man ٤ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I days Immediate Cause (Final disease or condition Priysician Cerebrovascular Accident resulting in death) /Medical Due to (or as a consequence of): Examiner Essential Hypertension 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, physicien Physician/Medical as the the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð þe Coronary Artery Disease 1 Yes 2 No 3 Probably 4 Unknown Completed should peeu Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2√xNo Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)Living 1 ☐ Yes 2 🔼 No Medical Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 or Attending 5 Pending investigation Injury 1 Natural death. 1 TYes 2 □ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npietely (Check only one) within 2. To the F To the 29b. Signature 29d. Date signed (Month, Day, Year) June 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Singh, Harjit 5410 Ritchie Highway Brooklyn Park Md 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 9 2004 Registrar

			· ·	State of Ma						-		egible.	
		•	For State Registrar	Otato of Ma	i y laria		tificate d				Reg. No.	004	22454
			Decedent's Name (First, Middle, Last)						-	2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Pauline H. Th	omas						Month 06 - 2	Day -	2004	5:30 A M
	Examin		4a. Facility Name (If not institution, give s	reet and number)			4b. City, Tow	m, or Location	of Death		4c. (County of Death	
			Montgomery General				01ney					ontgome	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours		8. Date of Birt (Month, Da	y, Year)	9. Birth	place (State or Foreign intry)
	Director		074-22-0077 Usual Residence of Decedent		90		}			04-11-1	.914_	Salt	ville, Va.
	yland now		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	Mar e-f st	ţċ	New York Westches	ter		Wh	ite Pla	ins					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Cod	de			10g. Citiz	en of What Cou	intry?
	ath w	rail	19 Tibbits Avenue					606				S.A.	
	er de	Funerai	Tr. Wallar States	2. Was Decedent E Armed Forces?		13. \	Was Decedent f Yes, specify (of Hispanic C Cuban, Mexic)rigin? (Spe an, Puerto l	cify Yes or No- Rican, etc.)	. 1	 Race - Amer Black, White 	
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9	J within 72 hours after death with the Maryland jiene then "naturel", or items 23a or 28e-f show the Mcdical Examiner must be notified at	ted	15. Decedent's Educ	atio <i>n</i>	1	6a. Deced	lent's Usual O	ccupation			16b. Kin	d of Business/I	ndustry
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pu	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden S	Sumame)	
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Maryland 21215-0036	C/ cg 700 100	11	19a. Informant's Name/Relationship (Type Robert W. Thomas/So		7	7536	Tarpley	Drive	2007	- c	or, Cay or	Town, State, Zi	p Code)
	tam 27 tam 27 tam 27	1	20a. Method of Disposition		20b. Place	of Dispo	od, Mai sition (Name o	f		ate	20c. Loc	ation - City or T	own, State
Baltimore,			1 XBurial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State		-	natory or other eaven (07-03	3-04	Silve	r Sprin	ng Md
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Ã	Departing any ir		Wanda C.	Bacon C	100 30	6/ 3	447 14t	h St.,	N.W.	Wash.	, D. (20010)
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0.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death	າ 5∟	Other (specifi	v)					
Q	that the de led by the a detached t		Part II. Other significant conditions con	inbuting to death but	t not resultir	ng in the ur	nderlying cause	e given in Par	t 1.	23e. Did to	obacco us	e contribute to	the cause of death?
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00	aw requires s been si 2 should l	Completed	Hx Congestive He	art Failu	re					24a. Was		24b. Were aut	opsy findings available
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of V	Physicien: this certific ral director,	၉	1 □ Yes 2 No	ospital:								□Other (Speci	fy)
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Division	at at	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	rv - At home	farm str		1 Yes 2		28f. Location (S	Street and	Number or Rui	al Route Number,
Di	after Dire	Certification:	4 Homicide determined	building, etc.		, , , , , , , , , , , , , , , , , , , ,	oot, tuolory, on			City or Tox			
-	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by th		29a. Certifier 1□ Certifying Phys	ician: To the best of	f my knowle	dge, death	occurred at th	ne time, date a	and place, a	and due to the	cause(s) a	and manner as	stated.
	n 24 he Fu	edical	(Check only 2 Medical Examin	er: On the basis of and mariner shat	examination ted.	and/or in	vestigation, in i	my opinion, de	eath occurre	ed at the time,	date and	place, and due	to the cause(s)
	To t To t	M	29b. Signature and title of certifier	, \]		^	29c. Lie	cense number			29d. Date	signed (Month,	
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(25/		30. Name and address of person who con					Dh	D	01	- 36	1 2002	<i>'</i>
	Sta	ato.	Chukwuemeka Nwos 31. Date filed (Month, Day, Year)	u, M.D.			rince !	LUTTID	νr.	Oine	y, M	1. 2083	<u> </u>
	Registi		JUN 2 9 2004	Beech .	K	freel	e l						

Clarence T. Underwood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-4194 State of Maryland / Department of Health and Mental Hygiene AKG 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Underwood June 26, larence 2004 7:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico River near Chaptico Wharf MAddox St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1₽M 2□ F 240-74-944 Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10a State 10d. Inside City Limits rai', or Itams 23a or 28a-f ahow Examiner must be notified at Accokeek 1 Fres 2 No Completed by Funeral Director Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. Int: If item 27 Is markad othar then "natural", or Items 23a or 2 20607 Drive 12. Was Decedent Ever in U.S. Armed orces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify Black 3 Widowed 4 □ Divorced Specify: The Medical 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Koland Underwood ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Nation of Date 20601 itam 2 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place Department of Important: If it any injury or o 1 ■ Burial 2 □ Cremation 3 □ Removal from State J4143 umberland Hem. Cem A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Ralph William Service S.E DC tre Washington 20003 1813 Paternae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician prowning disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 XNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? 2 No Division of Vital 1 XYes 2 🗆 No Yes. Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at SCENE XXYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred

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Control and Alumber of Bural Boute Number funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After Injury Natural 5 Pending death. 2 Accident 6-26-04 5:30 PM investigation Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) W. COM: CO KINEY Near Chaptio War S. Man à 4 Homicide River Wicomico thin 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. June 27, 2004 30. Name and address of leted sause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 3 0 2004 Registrar

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E SPEE		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			or Town, State, Zip Code)
N L		Mary Urquhart/Daughter	5922	15th Ave	. Hyattsville	e, Mary	1and 20782
or territary		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State	 Place of Dispo cemetery, crer 	osition (Name of matory or other place	Date	20c.	Location - City or Town, State
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Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe	Dice	21. Signature of 500 ral Service Licensee	Fc	2. Name and Addres	In Funeral He	ome	
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112)	30. Name and addressed person who completed dadse of death			DI	1. 11.	sville, MD 20783
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land ow		10a. State 10b. County	10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
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ath cert attendin for use	an/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3		pregnancy			23d. Date of d Month	elivery Day Year
· ō o b	sici	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown	death 5	Other	(specify)				
res that the de signed by the a	Phy	Part II. Other significant conditions of	contributing to death but not re	sulting in the	underlyin	g cause given in Part I.	23	e. Did tobacco	o use contribute	to the cause of death?
signe d be	d by							1 🗆 Yes	2 ₹No 3 □ I	Probably 4 Dunknown
w require been si	Completed						24	a. Was an	24b. Were	autopsy findings available
he lay	E D						4.5	autopsy performed?	death	completion of cause of
un: T	a)	25. Was case referred to medical				26. Place of De]Yes 2. ∰t k only one)	10 10	3 20 10
ny vital med hysician: The law his certificate has l	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpation	ent 3				6 ∑ Other (Sp	ecity) Daughter's
for Attending Physician: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be to		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injury at Work?	28d. De	scribe how in	jury occurred	"Residence
Attending Physicien: The law requires that the strength. Sector: After this certificate has been signed by the tuneral director, page 2 should be detached.	Certification:	2 Accident investigation			М	1 Yes 2 No				
	ij	3 Suicide 6 Could not b		home, farm, s ufy)	street, fac	tory, office	28f. Loc City	ation (Street y or Town, Sta	and Number or i ate)	Rural Route Number,
Fo the Hospital or Attention the Hospital or Attention 24 hours after deal To the Funerel Director:		29a, Certifier 1 Tercertifying Ph	nysician: To the best of my kr	nowledge des	ath occur	ed at the time, date and class	a, and due	to the cause	(s) and manner	as stated.
- 4 - 0	edical		niner: On the basis of examinand manner stated.							
To the within 2	Me	29b. Signature and title of certifier				29c. License number		29d. [Date signed (Mo.	nth, Day, Year)
		> 1/2 / Xn	Curren			D32636		June	25, 2	2004
/ (6)		30. Name and address of person who								
		Gary Sprous a			o Dr	ive, Cheste	er, î	Maryla	and 216	19
Regis	tate	31. Date filed (Month, Day, Year)	A. Registrar's Sign	nature	enth 1					

		1- State of Maryla	and / Depa	artment of Health and rtificate of Death	Mental Hygi	ene	221.58
Physici /Medi		Negistrar Decedent's Name (First, Middle, Last) Lela Bragg Williams		inoato of Dodin	2. Date of Death Month 06	Day Year 23 04	3. Time of Death 8:00 P
Examir		4a. Facility Name (If not institution, give street and number) 9200 Edwards Way #504		4b. City, Town, or Location of Deat Adelphi		4c. County of Dea	th
Funeral Director		5. Social Security Number 423-28-7568 Usual Residence of Decedent 6. Sex 1 □ M 2 □ XF 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, 07 28	Year) 9. Birr	hplace (State or Foreig ountry) ningham, AI
Maryland a-f show	tor	10a. State 10b. County 10c.	City, Town or Lo Adelphi	ocation			10d. Inside City Limit
th with the 23a or 284 Ist by rou	al Director	10e. Street and Number 9200 Edwards Way #504		10f. Zip Code 20783	10	g. Citizen of What Co USA	ountry?
72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show witcal Examination matter multibut at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
within 72 ho piene. r than "natur.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business	Industry
be filed tal Hyg ad othe	To Be Con	12th. 17. Father's Name (First, Middle, Last) MAjor Arrington	Pay		ne (First, Middle, M Bragg	U.S. Gover	cnment
1 and 2 should I Health and Men Iem 27 Is merks other traumatic		19a. Informant's Name/Relationship (Type, Print) Spencer Williams/Son	1836	ng Address (Street and Number or Ru Metgerott Rd. Un	ıral Route Number,		
Pages nent of ant: If ii		1 🗷 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	incoln 1	matory or other place) Memorial 6-29	-04 S	Oc. Location - City or Suitland,]	D .
parmit. Departr Imports any inji		21. Signature of Funeral Service Licensee		2. Name and Address of Facility MA 4217 9th. St. N.W	. Washing	ton, D.C.	20011
Physician /Medical Examiner		23a. Par(1) Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Due to (or as a constitution or condition or con	Artery		or respiratory arre	st,	Approximate Interval Between Onset and Death
aath cartificate be axecuted attending physician and for usa as the burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Chronic F Due to (or as a constitution of the constitution of the cause) c. Due to (or as a constitution of the cause)	sequence of):	sufficiency			
The law requires that the death cartifica tte has been signed by the attending ph bage 2 should be datached for usa as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	very Day Year
w requires that been signed b should be data	by	Part II. Other significant conditions contributing to death but not Hypertension	resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	Completed				24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
Attending Phyaician: Trideath. r death. ector: After this certifical by the funaral director, p	To Be	25. Was case referred to medical examiner? 1		ot 3 DOA Other: 4 Nursing H	ome 5 X Resider 28d. Describe how	nce 6 Other (Spec	cify)
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Dircompletely fillad in	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Exeminer: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
To the I within 2. To the I complet	M	29b. Signature and title of certifier	na)	29c. License number	29	d. Date signed (Mont)	Day, Year)
- (6)		30. Name and address of person who completed cause of death (I		Print)	Umatt	11. 10. 0	0702
Sta Registi		31. Date filed (Month, Day, Year) . Registrar's Signature	gnature		-ny attsv i	ile, MD. Z	0/02

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2:00 AM M CARRIE L. WATSON JUNE 24. 2004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 16010 Excalibur Rd. Bowie Prince Georges If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 M 2 XF Director 214-38-1091 63 Dec. 31, 1940 Virginia Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location r 28a-f show 10d. Inside City Limits Director 17 Yes 2 No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 16010 Excalibur Rd. 20716 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ₹ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ▼ Divorced natural', Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Program Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Watson Gertrude Justis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other training once. Marvis Brown/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

15551 Peach Walker Brive, Bowie Id. 20716
20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State * 4 Donation 5 Dother (Specify) Maryland Nat. Cem. 6/28/04 Laurel, Md. 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** n Lotan disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Co Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a lonsequence of): certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Records. 2 1 Ves 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate performed 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 144 1 Natural 2 Accident 5 Pending investigation death. MAM 1 ☐ Yes 2 ☐ No 1 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) l or A 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) m00045851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Cecil Johnson, 1221 Mecantile Lane, Upper Malboro Md. 20774 31. Date filed (Month, Day, Year) State JUN 3 0 2004 Registrar

Wronski, Jean Evelyn

			For	State of Ma		d / Dep	artmer	nt of He	ealth a		-		_	
	Physicia	an	State Registrar 1. Decedent's Name (First, Middle, L		elyn		rtificat	e of L	<i>Death</i>	2.	Date of Dea	Reg. No	2004	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, g		СТУП	VVIOI	,		Location of	f Death	lune		. County of Deat	
	Examin	eı	Doctor's Commun	ity Hospita			lé I la do	Lanl	ham If Under 2	M Hre To	Data of Dia			George's
	Funeral Director		5. Social Security Number 577–26–7298 Usual Residence of Decedent	Sex 7. Age 1 □ M 200 F	81	ast birthday, Yrs.	Months	Days	Hours	Min. A	Date of Birt (Month, Da Pril	ĽO's	1923 W	hplace (State or Foreign untry) ashington DO
	yland		10a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside City Limits
	Ba-f sl	Director		George's			1.04 700		anham			10- 0	tizen of What Co	1 Yes 2 No
	with the a or 2		10e. Street and Number 9608 Franklir	Street			101. 21	20. 20.	706			rug. Cr	USZ	
9	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Evaring must be notified at once.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Amed Forces? 1 Yes 2 1		S. 13.	Was Dece If Yes, spe	dent of His ocify Cubar		gin? (Specif , Puerto Ric	y Yes or No can, etc.)	-	14. Race - Ame Black, White	rican Indian, e, etc.
Ö	hours tural',	ed b	¥XWidowed 4 □ Divorced 15. Decedent's	Year or Dates: Education		16a. Dece	edent's Usu	ial Occupa	tion			16b. K	Wh:	
21215-0036	within 72 iene. than "na	Completed by	(Specify only highest s Elementary/Secondary (0-12) 12th		i+)		e kind of wi DO NOT l Store			of working			Privat	ie
פ	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, La	st)						-	irst, Middle,		Sumame)	
ylar	should be and Mental s marked o	ToE	Edward Bryar			Т					elyn E			
≥	and 2 shoath and 127 is mertreum		19a. Informant's Name/Relationship Steve Wronski			9610	Frar	klin		et, L	anham	MD		
altimore,	Pages 1 and of He sert of them and: If item arry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Content of the Content		C	lace of Disp emetery, cre Linc	matory or	other place	ery	Date 7/2/2			ocation - City or entwood,	
a	Departm Departm Importer any inju		21. Signature of uneral Service Lice	ensee	1.	1					•		uneral F	
8	805 29		23a. Parti. Enter the disease, or co	emplications that caused	the death						<u> </u>		MD 20 7 06	Approximate
	/Medical Examiner	Examiner	spock, or heart failure. List of disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Avv Due to (or as	a consequence	uence of): (A) uence of):						-		Interval Between Onset and Death
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.O. Box	The law requires that the death certificate be at the been signed by the attending physicial page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	□Ectopic p □ Other (s						23d. Date of del Month	ivery Day Year
<u> </u>	ires that the de signed by the a i be detached i		Part II. Other significant condition	s contributing to death b	ut not res	ulting in the	underlying	cause give	n in Part I.					the cause of death?
ğ	w require been sig should b	ted k	Hypertens	ion	1	-					10	Yes 2	ØNo 3□Pr	obably 4 Unknown
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/ita	ysicien: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only o			
of	Physicien: r this certific ral director,	2	1 Yes 2 No 27. Manner of Death	1 ∐ Inpatie	ITV	28b. Time		OA Othe	4 🗆 140		5 Residuel		6 ☐Other (Speciary occurred	cify)
lon	Attending I r death. ector: After by the funer	atlon	1, ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year)	Injury	м		t? Yes 2 □ 1	No				
Division	ol or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin		ury - At ho c. <i>(Specif</i>	ome, farm, s	treet, facto	ry, office		28	Location (S City or Tox	Street al wn, State	nd Number or Ru e)	ıral Route Number,
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1	(10)		-	completed cause of o				70 50	- Sa	175	357	A 1.	REGNI	8 20207
	Sta Regist	ate	31. Date filed (Month, Day, Year) LUN 2 9 200	32. Registr	ar's Signa	ature	ري	nec			,			

				1 - For Amend Item	#10e&191	Maryland per Th	G8333	artmen rtificati	104 e of	lealth a Las Death	and Me	ntal Hy	giene Reg. No	004	22461
				Decedent's Name (First, Middle,				-				Date of De			3. Time of Death
		Physici: /Medic		Carl Watts								June	2		11:28 A ^M
		Examin		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City,		r Location			4c	. County of Dea	ath
				Holy Cross				If the dead			Sprin				gomery
		Funeral			6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs. last	birthday) Yrs.	If Under Months	Days	Hours	Min.	. Date of Bir (Month, Da	rth ay, Year)		rthplace (State or Foreign country)
	6	Director		579-07-7620 Usual Residence of Decedent		93	113.				M	ay 6,	191	I Sou	th Carolina
		and and		10a. State 10b. County		10c. City, T	own or Lo	ocation							10d. Inside City Limits
		Many 1 sh	ē	DC					Was	hingt	ton				1 X Yes 2 ☐ No
		r 28a	Director	10e. Street and Numb#29 Ra	ndolph Pl	ace. N.W		10f. Zip		ii.iiig (COII		10g. Cit	izen of What C	country?
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		deat	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S.	13.	Was Deced	dent of H	lispanic Or an. Mexica	rigin? (Speci in, Puerto Ri	fy Yes or No	0-	14. Race - Am Black, Whi	
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	an	d be ental ked o	To B	Archie	Watts						A	lice (Cunn	ingham	
	JE Y	shound M	-	19a. Informant's Name/Relationsh	ip (Type, Print)		9b. Mailir	ng Address	(Street	and Numb	er or Rural F	Route Numb	er, City o	or Town, State,	Zip Code)
	ž	alth a		Kenneth L. Wat	ts - Son		11303	3. We	ombs	-Park	k Lane	, Gle	n Dai	le, MD	20769
	re,	tem item othe		20a. Method of Disposition	0		of Dispo	sition (Nan	ne of ther plac	ce)	Dat	9	20c. Lo	ocation - City o	r Town, State
	Ē	Page nent o		1 🏋 Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		Ft.					5/29/2		En.		ood, MD
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examinar matable notified at ODEs.		21. Sign ture of Funeral Service L	icensee	7111	22				Rd.,			cal Hom ., DC	e 20019
				23a. Part Enter the disease, or	complications that of	aused the death.	Do not ent								Approximate Interval Between
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	Во	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth 2 Fetal de	ath 3□	Ectopic pr		/				Month	Day Year
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RI	σ.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	۵.	Part II. Other significant condition	ns contributing to d	eath but not resultin	g in the u	nderlying c	ause giv	en in Part	I.	23e. Did t	tobacco i	use contribute t	o the cause of death?
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7	tal	en: tifica tor, p	O	25. Was case referred to medical						26. Place	e of Death (6				- A
1	>	Physicien: The lav this certificate has al director, page 2	To B	examiner? 1 ☐ Yes 2 🂢 No	Hospital:	Inpatient 2 ER	Outpatier	nt 3 DC	Oth Oth	er: 4□Ni	ursing Home	5 ☐ Resi	dence	6 □Other (Spe	ecify)
A	0 -	ng Pł		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury 28 th, Day Year)	b. Time of Injury		8c. Injun Wor			d. Describe	how inju	y occurred	
>	Sio	eath. or: A the fu	catl	2 Accident investig 3 Suicide 6 Could n	ation			М		Yes 2					
_	Division	or Att	Certification:	4 Homicide determi	ned 28e. Place buildi	of Injury - At home ing, etc. (Specify)	, tarm, str	reet, factory	, office		281	City or To			lural Route Number,
		pital ours a erel [29a. Certifier 11 Certifying	Physician: To the	best of my knowle	dne deat	h occurred	at the tir	me date ar	nd place, and	d due to the	cause(s	and manner a	s stated
		To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical E	xaminer: On the b	asis of examination ner stated.	and/or in	vestigation,	, in my o	pinion, dea	ath occurred	at the time,	date and	place, and du	e to the cause(s)
		To th Withir To th	X	29b. Signature and title of certifier				290	. Licens	e number				te signed (Mon	
	•				Musi				25 4	347			6-	24-	2004
N I)_	(5)		30. Name and address of person v					000	10 -		,	3.6-	0000	2
M					aj Chopra	a, M.D. Registrar's Signature		• Вох	838	19, 6	Gaithe	rsburg	g, MI	2088	3
		Sta Registr		JUN 2 9 2		kegistrar's Signature		de							

			1 - For State Registrar	State of Maryla		artment of rtificate of		d Mental Hy	gienę Reg. Nd	/	22462
	Physici		Decedent's Name (First, Middle, Last) BESSIE EVELENA W					2. Date of De Month JUNE	Day 16	, 2 ^{Year}	3. Time of Death 10:15P M
e:	/Medio Examir		4a. Facility Name (If not institution, give CLINTON NURSING	НОМЕ		CLI	or Location of D			PRINCE	GEORGES
	Funeral Director		5. Social Security Number 6. Security Number 10. Security Number 1	X 7. Age (In yrs	62 Yrs.	If Under 1 Yea Months Days		Vin. (Month, Da	y, Year)		hplace (State or Foreigr untry) FNEY, SC
	se Maryland 8a-f ehow	Director	10a. State 10b. County MARYLAND PRINCE GE		CAMP SP	RINGS			10 - Civi	zen of What Co	10d. Inside City Limits XX Yes 2 □ No
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exationar must be multipled at once.	by Funeral Dire	10e. Street and Number 4904 McKINLEY STRE 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of If Yes, specify Cu		? (Specify Yes or No tuerto Rican, etc.)	UNIT	ED STAT 14. Race - Ame Black, White Specify: BL	ES ncan Indian, a, etc.
0500-61212	vithin 72 hours ne. han "natural", a Medical Exe	Completed by	3 Widowed 4 Oivorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates:	(Give	dent's Usual Occi o kind of work don DO NOT use retir	upation e during most of ed)	f working	16b. Kir	nd of Business/	
Maryianu z	uld be filed w Mental Hygier arked other tl	To Be Col	8TH 17. Father's Name (First, Middle, Last) WORTH DAWKINS				18. Mother's BESS	Name (First, Middle	, Maiden	Sumame)	
Mai	und 2 sho alth and 1 27 is ma er trauma		19a. Informant's Name/Relationship (T) GAINWELL DAWKINS	/рө, Print) / BROTHER		ng Address (Stree McKINLE)		CAMP SPRI			
Dallilliore,	Pages 1 and 2 nent of Health a int: If item 27 i		20a. Method of Disposition XXBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	cemetery, cre	osition (Name of matory or other pi CTION CEN		Date JUNE 04		cation - City or	
Dall	permit. Departm Imports any inju		21. Signature of Funeral Service Dicens	VOV	2: N 4	2. Name and Add IARSHALL +308 SUIT	ress of Facility S FUNEF	RAL HOME O	F MA	RYLAND, D, MD 2	INC. 0746
	Physician /Medical Examiner		23a. Part1. Inter the disease, or complishook or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. <u>CARCINOMA</u> Due to (or as a conse	OF RIG						Approximate Interval Between Onset and Death
,00100	sate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.							
.O. BOX 0	that the death certificat ed by the attending phy detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past +2 ponths? 1 ☐ Yes 2+☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnan □ Other (specify)	су		2	23d. Date of del	ivery Day Year
ν L	Se no ed	by	Part II. Other significant conditions co	-	_		pven in Part I.				the cause of death?
חומפי שווא וס	The law ate has b page 2 s	Completed						24a. Was auto perf 1 🗆 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of 2 No
100	ician: T certificat rector, pi	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only			ywww.
	Phys this ral dii	on: To	1 ☐ Yes XX No 27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inj	ury at ork?	ng Home 5 Res 28d. Describe			cify)
DIVISION	r Atten ter deal irector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st		⊒Yes 2□No e				ıral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C		sician: To the best of my k iner: On the basis of exami and manner stated.							
•	To the To the comple	Me	29b. Signature and title of certifier	(D)			nse number			e signed (Monti	
	(3)		30. Name and address of person who c BAHRAM PISHDAD, N 31. Date filed (Month, Day, Year)		EORGIA	AVE., SI	UITE 3-4	41 SILVER	SPRI	NG, MD	20902
1	51	ate	ILIN 2 8 2004		ke the	All I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Rone ne 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lecer If Under 24 Hrs. Riber 6001 6 6. Sex **3** 5. Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days MCMM 2□ F Yrs. Director 577-88-6640 33 11/03/1970 Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. tnside City Limits or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No MD P.G. Hyattsville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23a 5397 Quincy Street apt#2 death v 20746 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the 2008. Maintenance Worker Private 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roosevelt Witherspoon Ethel Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeisha Witherspoon/sister 3431 Regency pkwy., Forestville, MD 20747

20a. Method of Disposition

1 Cremation 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) Mt. Washington, DC Olivet Cem. 06/30/04 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Taylor's Funeral Home 1722 N. Capitol St. NW Washington DC 20001 23a. Part1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Finat disease or condition resulting in death) **Physician** overwhelmino /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Respiratory Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one, Hospital: Other: 1☐Yes 2▼No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death
Natural
2 Accident Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No I Director: / investigation 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and Otle of contified 29d. Date signed (Month, Day, Year) 123850

CR (3)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State 31 Registrar

31. Date filed (Month, Day, Year)
JUN 2 8 2004

Steven

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Registrar's Signature

Prince Georges Hospi

		•	For Stete Registrar Angus Turned	State of Maryland /	Depa	artment of H	ealth and Me		jiene	14 2246	
	Physici	an	1 - Stete Registrar AMEND ITEM 1. Decedent's Name (First, Middle, Las	#IUE,I/GL9D FEA	Δ	hluwal	i a	2. Date of Dea Month July	th Day	3. Time of De Year 2004 1 20	ath A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			Location of Death	July	4c. County		
1	LAGIIII		Johns Hopkins			Baltim	ore				
	Funeral Director		5. Social Security Number 6. Se		birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day L1 20	, Year)	9. Birthplace (State or Fi Country) India	oreign
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City L	imits
	Maryland -f show	ō				Pitam Pu	ıra			ty Yes 2	
	with the Mise or 28a-fi	Directo	Delhi 10e. Street and Number	Deru	. J. 7,	10f. Zip Code			10g. Citizen of	What Country?	
	23a or		JD UD- 70C, SFS Fla	ts		1100)34		Ind	ia	
	dea Em	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hi	ispanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Rac Blac	e - American Indian, ck, White, etc.	
5-0036	al', or	by	1 ☐ Never Married	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	-	1□Yes X⊡XN o	Specify:			East Indi	an
က်	"na "na	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occupa kind of work done d DO NOT use retired	luring most of working	9	16b. Kind of B	usiness/Industry	
2121	d withir giene. rr than	omo	12th grade	College (1-4or 5+) na		f Employ	•		Lub O	il, Resell	er
pu	be filed Ital Hygi Id other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle,	Maiden Suman	ne)	
yla		2	Balbir S iug h				Parkash 1		0: 7		
Maryland	0 0 00 00		19a. Informant's Name/Relationship (7	ype, Print)	9b. Mail r	Briva Ar	ots, DB.	lock,	Vikas	Puri	
	ss 1 and 3 of Health item 27		Mahay Mayank-Sc 20a. Method of Disposition		elh of Dispo	1 , InQ13 sition (Name of natory or other place	a 110018	te	20c. Location -	City or Town, State	
E G	Pages ient of nt: If if		1 ☐ Burial 2 ☐ Cremation → ☐ '4 ☐ Denation 5 ☐ Other (Specify	Hemoval Irom State		India	I .	/04 F	uniab	i Bagh, De	lhi
Baltimore,	parmit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licen		22 M	Name and Address	s of Facility				
	•		23a. Part 7. Inter the disease, or communication of the communication of	olications that caused the death. D	o not ent	er the mode of dying	g, such as cardiac or	respiratory arr	est,	Approximate Interval Between	en
	`hysician		Immediate Cause (Final disease or condition	. CORONAR						Onset and Dea	ith
	/Medical Examiner		resulting in death)	Due to (or as a consequence			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			3	
1	LAGITITIES	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):						
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	-	/-						
o,	executed an and rial-transit	Еха	resulting in death) Last	Due to (or as a consequence	e of):						
8760,	ate be ex hysician the buria	dlcal		d							
39 x	death certifica attending ph for use as the	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy		-11.50			004 B	An of delivery	
Вох	attend for us	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)				te of delivery onth Day Yea	ır
0	that the de led by the a detached	hysi	1 Yes 2 No 9 Unknown	9□ Unk <i>n</i> own							
Vital Records, P	sign sign ba	d by Physiclan/Me	Part II. Other significant conditions of	ontributi <i>n</i> g to death but not resulting	g in the u	nderlying cause give	en in Part I.		bacco use cont es 2 □ No	ribute to the cause of deat	
COL	w requ	Completed						24a. Was a		Were autopsy findings ava	ulable
Re	The law ate has b page 2 si	шо						autops perfor	med?	prior to completion of caus death? 1 □ Yes 2 □ No	e or
ita		BeC	25. Was case referred to medical examiner?	1005591001			26. Place of Death				
of V	Physician: r this certific ral director,	2	1 Tyes 2 No	Hospital: 1 Inpatient 2 ☐ ER/0			4 Nursing nom			- 1 1 2 2	
	ding P	lon:	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	. Time of Injury	Work		3d. Describe h	ow injury occur	red	
Division	Attending in death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be		farm, str					per or Rural Route Number	
É	al or A safter I Dire	Certification:	4 Homicide	building, etc. (Specify)		, , , , , , , , , , , , , , , , , , , ,		City or Tow	n, State)		
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical (ysician: To the best of my knowled liner: On the basis of examination and manner stated.							
	within 24 h To the Fur completely	Me	29b. Signature and title of cortifier			29c. License	e number	2	9d. Date signe	d (Month, Day, Year)	
			MAKE.	Medical DOCTOR		RE	5-000		July	17,2004	
	3		30. Name and address of person who			Print)					
,,,		11.35±3	500 KIM, 600 N 31. Date filed (Month, Day, Year)	orth Wolfe Stre	et, e	Saltimore	, Marylar	rd 21	287		
	Sta Regist		JUL 1 9 2004	32. Hegistrar's Signature	bon	le le					

			1 For Amend Item 23	State of M Sa per Dr	aryland/D	partment of H 7/19/04dhb Certificate of L	ealth and M Death		giene Nog. Nog. O. O.	
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith 200	3. Time of Death
	Physici /Media		Frank	J.	Aloi	s		July	2 2004	12:15 p ^M
1	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of	
			Country Home			Harwoo	d		Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex 126-10-5098	7. Ag	e (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 9,	Year) 1917	9. Birthplace (State or Foreign Country) New York
	pu .		Usual Residence of Decedent							
	aryla shov	_	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	he M	ctc	MD Anne Aru	ndel	West					1 ☐ Yes 2X1No
	with t	풉	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	s 23	Funeral Director	Box 3	10 Mac Decided	From in U.S.	20778		- 4 1	USA	
	item rerr	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Amed Forces? 1XXX es 2 □		 Was Decedent of Hi If Yes, specify Cubar 	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
36	Ir, or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	40	1 ☐ Yes 2XXNo	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then 'nstursi', or items 23s or 28s-f show he Mudical Exeminer must be restlited at		15. Decedent's Educ	cation	16a. D	ecedent's Usual Occupa	ation		16b. Kind of Busin	ness/Industry
75	n "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or :		Give kind of work done di fe. DO NOT use retired,	luring most of work	king	700. 71110 01 0001	
21	d with	E O	Lionionary/Socondary (0-12)	4		vigator			U.S. Ai	r Force
פ	othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
Maryland	should be filed withir and Mental Hygiene. Imarked other than umatic event, the Ma	70	Sullivan Alois				Unknow	n		
an	and I		19a. Informant's Name/Relationship (Typ		19b. N	Mailing Address (Street a	nd Number or Rui	ral Route Number	r, City or Town, St	ate, Zip Code)
	5 ₹ 7 ±		Peter B. Alois (So	on)		rican Embas		1280, Bo	x 10 APO	AE 09880
ore			20a. Method of Disposition 1 ☐ Burial 2\(\text{Cremation}\) 3 ☐ Re	emoval from State	20b. Place of D cemetery,	isposition (Name of crematory or other place	9)	Date	20c. Location - Ci	ty or Town, State
Ē	mit. Pages partment of loorlant: If its injury or of		'4 □Donation 5 □ Other (Specify)		Metro	Crematory	7/7/	2004	Baltimor	e, MD
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License	pe-		22. Name and Addres Hardesty 12 Ridge			.A. lis, MD	21401
	10		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	ations that caused	the death. Do no					Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition	Renal	Failur	^ 0				Onset and Death Supersupersupersupersupersupersupersupers
	/Medical		resulting in death)		a consequence of)					2 769.3
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	D 15	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)					
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387	phys phys s the	dicai	d							
		Φ.	IF FEMALE:	3c. If yes, outcome	of pregnancy	-1/1			711530	
Вох	atter for u	Physician/M	in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	•
o.	the d y the	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	timo or dough	J Girler (specify)				
٥.	The law requires that the death certi le has been signed by the attending rage 2 should be detached for use a		Part II. Other significant conditions con	tributing to death b	ut not resulting in th	ne underlying cause give	n in Part I.	23e. Did tol	pacco use contribu	ute to the cause of death?
of Vital Records,	uires n signe	d by						1 🗆 Ye	es 2 ¥ No 3 [□ Probably 4 □Unknown
<u>S</u>	w require been sign	ompieted						24a. Was a	n 24h We	re autopsy findings available
Re	The lav ate has page 2	шc						autops	y prio	r to completion of cause of
ta		C	25. Was case referred to medical				26 Place of Deet	1 Yes		Yes 2□No
5	Physician: this certificanal director,	O B	examiner?	ospital:	ent 2 ER/Outpa	atient 3 DOA Othe	26. Place of Deat		e) ence 6 □Other((Carata)
		n:T	27. Manner of Death	28a. Date of Inju	ry 28b. Tim	e of 28c. Injury			ow injury occurred	(Ѕреспу)
jo	Attending r death. Ctor: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	<i>y Year)</i> Inju		? es 2 □No			
Division	Attencer death	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, et	ury - At home, farm	, street, factory, office		28f. Location (St	reet and Number	or Rural Route Number,
Ö	tal or rs aft el Din ed in	Certification:		building, or	c. (Spoony)			City or Town	i, Sialej	
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 To Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis of and manner sta	examination and/o	leath occurred at the time or investigation, in my opi	inion, death occur	red at the time, di	ate and place, and	er as stated. I due to the cause(s)
	Withir Comp	Me	29b. Signature and title of certifier	2-	_	29c. License	number	2	9d. Date signed (A	Month, Day, Year)
•			Mayne of	Surban	my my	D	28228	5	July 6, 2	004
			30. Name and address of person who cou		eath (Item 23a) (Ty	pe, Print)		0.	<u> </u>	
-			Wayne Bierbaum	/	+ owen	suilly RO	West	Kiver	mo	20778
3.	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	pe, Print) Suille Ro				

State

Registrar

E. Sell

1 9 2004

31. Date filed (Month, Day, Year)

M.D.

32 Registrar's Signature

Anshel, Bernand

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name /First Middle Last JULY **Physician** 14 11:50 P M 2004 AGUS MIRIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE NORTH OAKS HEALTH CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 0CT.26,1915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 20 F MASS. 88 215-54-2286 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. Int: If item 27 ie marked other than "naturel", or Items 23a or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10h Counts 10a State item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No PIKESVILLE MD BALTIMORE Direct 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 21208 USA 725 MT. WILSON LANE by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes 2 No Yes, Give 1 □ Never Married 2 □ Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) RELIGION REBBITZEN 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be SHORE DORA **MEYERSON** BERNARD ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: if item 27 ie any injury or other tret once. DEBORAH AGUS / DAUGHTER 2200 ARDEN ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BETH EL MEMORIAL PARK 7/16/2004 RANDALLSTOWN, MD 21. Signature of Funeral Service Usersee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementin **Physician** end-stage Alzheimers disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 to No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown nas been signed by 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□ No certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Dether (Specify) (ASS is led Living 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier N.S. Rajapakse, MD D 57 465 Mumpulnero 7/15/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roisterstown, MD 21136 25 Main St, suite 200 -Rajapakse M.D. 31. Date filed (Month, Day, Year) 32/Registrar's Signature State JUL 1 9 2004

Registrar

		1 - State Registrar	3State of Mary 689	Cer	rtificate of l	Jeam		Reg. No.	201	0016
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Physic /Medi		Gladys Pauline	Bassford				July	7, 200	4	1:00 PM
Exami		4e. Fecility Name (If not institution, give 406 Bay View Dr			4b. City, Town, or Edge	Location of Dea	ath		nty of Death le Arus	
Funeral		Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year)	Cou	place (State or Fore ntry)
Director		Usual Residence of Decedent				!i	June 2	+, 191	/ VII	ginia
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f Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No erto Rican, etc.)	В	Race - Ameri Black, White, cify: W	
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27 ie n r traun		Ralph Bassford/s			Bay View				1037	<i>p</i> 0000 <i>y</i>
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Part		Examiner		Lacora were succe											
Second S		_	ğ	if any, leading to immediate	Due to	(or as a consequence of)									
Second S		outed nd ransi	Ē	that initiated events	С.										
The control of the	oʻ	exe an af urial-t		resulting in death) Last	Due to	(or as a consequence of)									
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CV CYRIAC-M-D BO21 RITCHIR WWY, PASADRNA, MD 20 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ita	iclen. ertific	Be	examiner?	Hospital:			\ \tau_1		e of Deat	h (Check only	one)		AS5/5	7 E.h
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CV CYRIAC-M-D BO21 RITCHIR WWY, PASADRNA, MD 20 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		o the o the omple	Me				290	License	e number			29d. Date	signed (Month,	Day, Year)	
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State		V		CV CYRIA	C-M-D	8021 Ri7	CHIR	bu	١٤.	PA.	SAORN	A, (40 2	1122	
		St	ate	31. Date filed (Month, Day, Yea	ar) 32.	Registrar's Signature							•		
				min 1 9 201	14 Sens	tra &	Spark	/							

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Mar	yland / Depa	artment of	Health and M	-	•	•
			1 - State Registrar		Ce	rtificate of	Death	F	leg. N <u>2</u> 0 0 4	22470
	Physici /Medic		1. Decedent's Name <i>(First, Middle, La</i> MARY L •	BUCHANAN				2. Date of Dea	th Day Yea	
	Examir		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town,	or Location of Death		4c. County of De	eath
			MERCY HOSPICE	1		-	IMORE		N/A	
	Funeral Director		214-14-3586	Sex 7. Age (i 1 □ M 2 X X	In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day OCT 9	, Year) (lirthplace (State or Foreign Country) MARYLAND
2	and and		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
4.6	Mary fied	ō	MARYLAND N/A		ВАТ.Т	IMORE				1⊠Yes 2 □ No
5	r 28a	Directo	10e. Street and Number		2/1111	10f. Zip Code			l0g. Citizen of What (Country?
10	death with the Maryland ms 23a or 28a-f show r nust be notified at	a D	2136 DRUID HI	LL AVENUE		212	17		U.S.A.	
36	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or liems 23a or 28a-1 show other than "natural", or liems 23a or 28a-1 show event, It a Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married **Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 Yes XXNo	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: B]	
Ş	tura stura	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busines	
212	filed within 72 Hygiene. other than "na! ent, It e Medic	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work	king		
21	id with giene er tha	EOC	6th grade	College (1-401 34)	HOU	SEKEEPER			DOMEST	IC
D D	be filed hat Hygi od other event, I	Be (17. Falher's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>ya</u>		2	SAMUEL JORDAN				ELIZAB	ETH NEWM	AN	
Maryland 21215-0036	2 sa sa sa sa sa sa sa sa sa sa sa sa sa		19a. Informant's Name/Relationship	•		•			r, City or Town, State	
	s 1 and if Health item 27 other tr		Betty Buchanan/D		2136 20b. Place of Dispo			Baltimo Date	re, Maryla	
Baltimore,	Pages nent of It int: If ite		1 Burial 2 □ Cremation 3 [Removal from State	cemetery, crei	matory or other pla	ice)		20c. Location - City of	
	permit. Pag Department Important: any injury o		'4 □ Donation 5 □ Other (Speci	1	GARRISON 20		and the second second			LLS, MARYLAND
Ba Ba	permit. Pages Department of I Important: If it any injury or o		> // Prog	Kaller	1	206 W NO	RTH AVENU	E	FUNERAL HO	OME P.A.
) -1	Pnysician		23a. Part1 Entel the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.			ing, such as cardiac		est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	,				
		J.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a c	ouseunence off.					
	nted nsit	Examiner	Cause (Disease or Injury	20010 (0. 0000						
/60,	te be executed ysician and ne burial-transit		that initiated events resulting in death) Last	C. Due to (or as a c	consequence of):					-
	cate t	dical		d		•				
BOX 6	leath certificat attending phy I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	ргедлапсу				23d. Date of d	elivery
Ö.	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown		Ectopic pregnand Other (specify) _	ey		Month	Day Year
٠ <u>٠</u>	s that I	by Ph	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	pacco use contribute	to the cause of death?
Records ,	w requires been sig should be							1 □ Y	es 2□No 3□F	Probably 4 Unknown
ဝ	law re as bee 2 sho	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
ř		E						perform	ned2 death?	es 2 No
Vital	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)	
5	Physician: this certifice ral director, I	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatier	it 3 L DOA	-	me 5 Reside		ecity) hospice
	After une	ion:	27. Manner of Death 1 Attural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Wo	rk?	28d. Describe ho	ow injury occurred	
DIVISION	len eatl or:	licat	2 Accident investigation 3 Suicide 6 Could not be	Ope Diego of Injury	- At home farm str]Yes 2□No	28f Location (St	reet and Number or F	Rural Route Number
2	ital or Attend irs after death ral Director: ,	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town	ı, State)	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1. Certifying Pl 2. Medical Example one)	ny sician: To the best of n miner: On the basis of ex and manner stated	tamination and/or in	h occurred at the ti vestigation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1 0		29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)
				my m		D4	0854		7/15	2004
	2		30. Name and address of person who	completed cause of deat	th (Item 23a) (Type,	_	0	•	1 -	
	V \	to	31. Date filed (Month, Day, Year)	eng 301 32. Registrar's	Signature.	iul Pl	+12C1	more	mel ?	2021
	Sta Registr		1111 1 9 2004	As such A	Coaste	1				

State of Maryland / Department of Health and Mental Hygiene

				State of Maryland	Certificate		Worker 11	0.0	01 0	O f m .
	D		Decedent's Name (First, Middle, Last)	^	- Cortinoato	0, 200	2. Dete of D		3: T	me of Death
	Physicia		AUDREY M	RITIER			July	14 2 -	Year	oopm
3	/Medica Examine		4a Fecility Name (If not institution, give :	street end number)		4b. City, Town, or				00 71. [
	Examine		FUTURE CARFO	ChESAPEAL	E	ARNO	DLD	ANNE	EARIDA	MEL
	Funeral		5. Social Security Number 6. Sex		t birthday) If Under 1 Months	Year If Under 24 Hrs Days Hours Min		irth	9. Birthplace (S	Stete or Foreign
	Director	ļ	218,46,0019	IM 28 72	Yrs.	1000	Aug	27,1931	MARY	AND
	p .	1	Usuel Residence of Decedent 10a. Stete 10b. County	10c City T	own or Location			/	10d Inc	ide City Limits
	show	5	M Aus A	- Or ward	1 Dalala					Yes 2 No
	th with the Maryle 23a or 28a-f shor	8	10e. Street end Number	RUNDE	10f. Zip C) Ma		10g. Citizen of V		
	A P	ă	408 114.00	20	10.20	1012		Tog. Olizeri of	. S.A	A
	72 hours aftar death with the Marylend natural', or items 23e or 28e-f show sicel Examiner must be notified at	Funeral Director	11. Maritel Status	12. Was Decedent Ever in U,S.	13. Was Deceder	t of Hispenic Origin? (5	Specify Yes or N	o- 14. Rac	e - American Indi	an.
_	ftar dea	듄	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		t of Hispenic Origin? (S Cuban, Mexican, Pue	rto Rican, etc.)	Blac	ck, White, etc.	
07(urs aff		3 Widowed 4 □ Divorced	If Yes, Give Yeer or Dates:	1 ☐ Yes 2 0	No Specify:		Specify	Whi	TE
21215-0020	"natura!",	Completed by	15. Decedent's Educ (Specify only highest grade	cation 1	6a. Decedent's Usual (Occupation	rkina	16b. Kind of B	usiness/Industry	
21	- 2		Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	done during most of wo	uking	1 1	1 1	
	e filed within I Hygiene. other than	5	10	(JEUSSIN	9 GUAR	D	LOCAT C	20 VERN	MEN7
pu	al H oth	Be	17. Father's Neme (First, Middle, Last)			18. Mother's Na	me (First, Middle	e, Maiden Sumem	10)	
yla	2 should be and Mantal is marked o	၉	VEKNON .	DAV15		EDV	IH EI	SISTIKI	>	
Maryland			19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Address (treet and Number or R		NEW Auto-	State, Zip Code)	
	end lealth m 27		TERKYGKVITITA, I	MUGHTER 1	of Disposition (Name	skook CI.	YAGADE		2112	
0	t of t		20a. Method of Disposition 1 Method of Disposition 3 □R		etery, crematory or other	r place)	Date	20c. Locetion -	City or Town, Sta	ate
Ę.	tant:		4 □ Donation 5 □ Other (Specify)	LAK	EMONT MI		7-19-04	DAVIDSON	UVILE, M	1D.
Baltimore,	permit. Pages 1 end Depertment of Health Important: if item 27 any injury or other to once.		21. Signature of Funeral Service License			Address of Fecility erty Family Funeral	Home And Pro	metion Contor	DA	
	70 = 6 a	Ť	Will Ha	mus		2601 Mountain Roa			r.A.	
	7		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only of	ations that caused the death. I	Do not enter the mode of				Appro	ximate al Between
	Physician								Onset	and Death
100	/Medical Examiner		Immediate Cause (Final disease or condition	CARCINON	A OF L	LING				
	36	_	resulting in death)		a consequence of):					
	be is	Examiner	۵ 🕳 ه							
	icate be executed physician end s the buriel-transit	xan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to (or as	e consequence of):					
68760,	death certificate be execu e attanding physician end od for use es the buriel-tra	<u>8</u>	cause. Enter Underlying Cause (Disease or injury							
587	tificate ng phys es the	edical	resulting in death) Last	Due to (or as	e consequence of):				f	
Вох	certif ding use e	٤	d	•						
ĕ	iras that the death cer signed by the attandir d be datached for use	by Physician/M	Death Other designations and designation		and the state of t	and the second second	not Di		- Authora - A- Ab	
O.	the cy the achec	lys	Part II. Other significant conditions con	tributing to death but not resultin	ig in the underlying cau	se given in Part I.		tobacco use cor	3 Probably	
Д,	that ned be date	V P					''	ries Zipato	3 Probably	4 DIKIOWII
Records,	requiras that the	훘					24a. Wa	s an autopsy	24b. Were auto	opsy findings
000		Completed					реп	ormed?	completio of death?	n of cause
Re	he la a has aga 2	E					10	Yes 2ZNS	1 □ Yes	2∏ No
Vital	ifficat for, p		25. Was case referred to medical			26 Place of De	ath (Check only		1	
<u> </u>	s cer direct	10 B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER.	/Outpetient 3□ DOA	Othor:	1100	idence 6 □Oth	er (Specify)	
0	Physic this eral coral	١	27. Manner of Death			Injury at Work?	+	how injury occurr		
ior	ath. F: Afta e fun	읉ㅣ	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	Injury M	1 ☐ Yes 2 ☐ No				
Division	Atte	<u> </u>	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fectory, o	ffice	28f. Location	(Street end Numb wn, State)	er or Rural Route	Number,
Ö	s affer se a	Certification:		building, etc. (apacity)			Ony or Fe	·····, O:aio)		
	pepil hour inere ly fills	edical	29a. Certifier 112 Certifying Phys	iclan: To the best of my knowled	dge, deeth occurred at	he time, date end place	e, end due to the	cause(s) and ma	nner as stated.	uso(s)
		-	one) 2 Medical Examin	er: On the basis of exemination and menner stated.	endor investigation, in	my opinion, death occi	urred at the time,	, date and place, (end due to the ca	use(s)
	the He Hin 24 he Fe				20 a 1	icense number		00 1 0 1 1 1 1		
		_	29b. Signeture and title of certifier					29d. Date signed	d (Month, Dey, Ye	ear)
D	To the H within 24 To the Fu complets	_	1 money	mo	i	5753	1	July	15, 2	004
D	To the Hi within 24 To the Fi complets	∑	1 money	npleted cause of death (Item 23	i	5753	1	July	15, 2	004
)	To the H. within 24 To the F. complete	>	1 money	mpleted cause of death (Item 23	i	5753	1 wil	July	15, 2	004

			Tor State Registrar	State of Marylan	d / Department of h Certificate of		ntal Hygiene		22472
>	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last Author 4a. Eacility Name (If not institution, give	1. Carter		2. or Location of Death	Date of Death Month Da	Year 200	
	Funeral Director		5. Social Security Number 422 -44-4335 Usual Residence of Decedent	x 7. Age (In yrs. I	last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year)	9. Birt	hplace (State or Foreign
	h the Maryland or 28a-f show a notified at	Irector	10a. State 10b. County MD Baths 10e. Street and Number		y, Town or Location VES VIII e 10f. Zip Code		10g. Cit	tizen of What Co	*
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or ltems 23a or 28a-f show The Medical Examinet must be notified al	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21208 Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Ame Black, White Specify: B	nican Indian,
21215-0036	d within 72 giene. ir than "nat	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire PU+C5557	during most of working	tor	Colle	
Maryland	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, II	To Be (17. Father's Name (First, Middle, Last) Nathan M. (2) 19a. Informant's Name/Relationship (7)	arter Se	19b. Mailing Address (Street		Belle Dute Number, City of	Hick or Town, State, Z	
Baltimore, Ma	es 1 an of Heal of Item 2 r other		Tean R. Care 20a. Method of Disposition 1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Disposition (Name of emetery, crematory or other place)	Date	20c. Lo	ocation-City or	mo ZIZOS Town, State
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	و ا	22. Name and Address VOL	esta C.C.	eene Fu. Randal	neral	mb. 21 133 Approximate
	Priysician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	4.5	ccancev	ng, such as cardiac or re	spiratory arrest,		Interval Between Onset and Death
8760,	ate be executed hysician and he burial-transit	ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b					10/2001
O. Box 6	The law requires that the death certifics the has been signed by the attending ptoage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	I death 3 Ectopic pregnance	у		23d. Date of deli Month	ivery Day Year
Ω.,	w requires that been signed b should be dete	by	Part II. Other significant conditions co	•	ulting in the underlying cause gr	ven in Part I.		use contribute to	the cause of death?
Vital Records,		e Completed	25. Was case referred to medical			26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 No	prior to death?	stopsy findings available completion of cause of
of	ling Phys n. After this funeral dii	atlon: To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wo	ner: 4 🗆 Nursing Home			cify)
Division	i gitte	al Certification:	3 ☐ Suicide 6 ☐ Could not be determined 29a. Certifier 1 ☐ Certifying Phy	building, etc. (Specify	wledge, death occurred at the ti	me, date and place, and	Location (Street art City or Town, State due to the cause(s)	a) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	one)	iner: On the basis of examinal and manner stated.	tion and/or investigation, in my				
	P P P P P P P P P P P P P P P P P P P	Σ	29b. Signature and title of certifier Pan Jakon	n	29c. Licen D 53			te signed (Month	
	10		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	Ballimor	e, MD	21231	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa					

		1 - State Registrar AMEND ITEM	State of Maryland / #4c PER PHY G83	Department of Health and 3 Certificate of Death	Mental Hygie Reg.	0.0 - :
Physici /Medic		1. Decedent's Name (First, Middle, Las Robert E	Cooke		2. Date of Death Month	Day Year 10.0 P
Examin Funeral Director	er	4a. Fecility Name (If not institution, give Rux ton Health 5. Social Security Number 6. Se 249-09-1703	+ Rehabilitat		rs. 8. Date of Birth (Month, Day, Ye	4c. County of Death BALTO 9. Birthplace (State or Foreign Country) 2
D	tor	Usual Residence of Decedent 10a. State 10b. County Rail	nove Pike	wn or Location	2-3-19	10d. Inside City Limit
th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 25 Tentmill (c)		10f. Zip Code Z1Z08	10g.	Citizen of What Country?
72 hours after deeth with the Maryland naturel', or flems 23a or 28a-f show Itsal Examirer must be notified at	þ	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No II Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- orto Rican, etc.)	14. Race - American Indian, Black, White, etc.
2 should be filed within 72 hours after dee and Mental Hoggene. Is marked other them "naturel", or flems eumatic evant, the Medical Examinet management.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation 16 to completed) 16 College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired) ASSemble	orking	. Kind of Business/Industry
nould be file I Mental Hy narkad oth	To Be		ooke_	Julia	ame (First, Middle, Maid	recloud
of Health of Health if item 27 or other tr		19a. Informant's Name/Relationship (7. Anita Cooke 20a. Method of Disposition 1 Borrial 2 Cremation 3 D	Wife 20b. Place	b. Mailing Address (Street and Number or Its STentmill (9 nc of Disposition (Name of ery, crematory or other place)	Date 20c	CSUINE MUZIZUS
permit. Pag Department Importent: I any injury o once.		' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens	Cely	Vanda Coverel	my Sevi	omac, UG 3 Rd 21/33 ~ RG, ndy/stan MI
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	e not enter the mode of dying, such as cardio CARDIO e of):	-	Approximate Interval Between Onset and Death
ificate be executed g physician and ss the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a sonsequence Due to (or as a consequence			
The law requires that the death certificat ite has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed be should be deta		Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I. ALEASE		to use contribute to the cause of death?
icien: The law re certificate has be rector, page 2 sho	Completed by				24a. Was an autopsy performed 1 Yes 201	
Phys this al did	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man ol Death Natural 5 Pending 2 Accident investigation		Other	Ath (Check only one) Home 5 Residence 28d. Describe how in	
To the Hospitel or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, lactory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
To the Hospitel within 24 hours a To the Funaral I completely filled	edicai	one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	ie, death occurred at the time, date and plac nd/or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To T Com	Σ	29b. Signature and title of certifier	Lallham	29c. License number	29d. [Date signed (Month, Day, Year)
N		ASNEEM A	ompleted cause of death (Item 23a)		AVE B	19/04 Aen MD 24208
Star Registra		31. Date liled (Month, Day, Year) 输销 1 9 2004	32. Registrar's Signature	Sports		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) . Day 2004 July 17, **Physician** 7:56 Edna Leona Cullison /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3611 Red Rose Farm Road Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 M 25F Yrs. 73 Pennsylvania **Director** 215-28-3700 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or Itema 23s or 28s-f show event, the Maylcal Examiner must be notified at 1 ☐ Yes 3 ☐ No Directo Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 3611 Red Rose Farm Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ☐Yes 30XNo Maryland 21215-0036 1 ☐ Yes XX No If Yes, Give Year or Dates: Specify Be Completed by 3€ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: if Item 27 is marked off iury or other traumatic even William Hill Vena Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Worton Road, Essex, Maryland 21221 Brenda Yutzy (Daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 Donation 5) Other (Specify) July19,2004 Bayview Crematory Baltimore, Maryland 21. Signature of Farieral Source Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition **Physician** INFARCTION YOCARDIAL resulting in death) /Medical Due to (or as a consequence of) **Examiner** CORO NAR RTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: page . certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ☑ No tuneral director. 25. Was case referred to medical 26. Place of Death Check on one examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1⊠Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38363 M Mehrelses rono 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCESCO 6569 NICHAPLES 1 RASSO MD 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.') 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death **Physician** Dav Month John Dale Carter /Medical 07-15-2004 11:00am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 939 Wilmington Ave Baltimore City N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 11-07-1921 **Funeral** Birthplace (State or Foreign Country) 1**▼** M 2□ F Director 218-18-69 82 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location ir than "natural", or itame 23a or 28a-f ahow the Medical Examine must be notified at 10d. Inside City Limits Director YOS 2□No Marvland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 939 Wilmington Ave USA fited within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give 1938 to Year or Dates: 1941 1 Yes 2 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Bethelaham Steel other injury or other traumatic evant, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filt tment of Health and Mental H tant: If item 27 is marked oth Be 18. Mother's Name (First, Middle, Maiden Sumame) Tom Carter Carrie Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Charlotte Stoll - Spouse 939 Wilmington Ave. Baltimore, Maryland 21223 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Baftimore Crematory permit. Page Department o Important: ff any injury or once. 07-19-2004 Baltimore, Maryland Loudon Park Funeral Service Lice 21. Signatura 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1 Enter the disease, or complications that care shoot, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER IETASTATIC MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 1 Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Profifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as stated at the time, date and place, and best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Chack unity one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asanthaleuma no Tirly 30. Name and an dress of person who completed cause of death (Item 23a) (Type, Print) ROLLING ROAD # 108 Kuman VASANTHA 516. N. 31. Date filed (Month, Day, Year) UL 1 9 2004 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

O. Box 68760,

Division of Vital Records,

ORIGINAL

			1 - For State Registrar	State of Maryl		artment of I rtificate of		_	giene Reg. NG. ()	11. 2	21.76
	Physici		Decedent's Name (First, Middle, Last) CHARLES		N CRU	ım		2. Date of De Month JULY	ath Day	Year 2004	3. Time of Death
	/Medie Examir		4a. Facility Name (If not institution, give Frederick Memo	street and number)			or Location of De		4c. Count	y of Death	
	Funeral Director			7. Age (In)	rs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 H Hours M	in. NOV 4		9. Birthpla	ice (State or Foreign Land
	he Maryland 28e-f show officed at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Carrol		City, Town or Lo	Keymar					d. Inside City Limits 1 ☐ Yes 2 ☒ No
	s 23e or 2	Funeral Director	12424 Keymar Road			10f. Zip Code	2175			U.S.A.	
9600	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "netural", or items 23e or 28e-f show event, the Medical Examinar must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		941 to 945	1□Yes 2√2 No	Specify:	(Specify Yes or No erto Rican, etc.)	Specia	ce - Americar ck, White, et	
Maryland 21215-0036	C * -634	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occuj kind of work done DO NOT use retire CCOUNTAN	during most of w d)	vorking	16b. Kind of E		stry
yland	should be filled within and Mental Hygiene. s markad other than umatic evant, Ins M	To Be (17. Father's Name (First, Middle, Last) Henry Clay Crum				Mar	lame (First, Middle, ry France:	s Kolb		
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (TyVictoria Lynn Hain) 20a. Method of Disposition 1	es/Daughter temoval from State Entombment	1242 D. Place of Dispo cometery, crer 1t. Oliv	4 Keymar sition (Name of natory or other plate et Cemete 2. Name and Addre	Road, kery Jul	Rural Route Number Keymar, Ma Date Ly 17, 200 Sford Fund	aryland 20c. Location 04 Free	21757 City or Town derick	
8760,	the death certificate be executed y the attending physician and uipagic tened for use as the burial-transit and	dicai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, large large time cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a const.) Due to (or as a const.)	sequence of):	906 Ear er the mode of dyi		h Street	, Freder	l tr	MD 21701 proximate nterval Batween onset and Death M (NT)
.O. Box 6	at the death certifics by the attending pt tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	/			te of delivery onth Da	
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Division of Vital	ng Phys fter this meral dir	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year,	ER/Outpatien 28b. Time of Injury	28c. injur Wor	er: 4 Nursing	eath (Check only of Home 5 Resid 28d. Describe h	lence 6 Oth		
Divis		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (S City or Tow		er or Rural R	loute Number,
	To the Hospital or within 24 hours after To the Funaral Dircompletely filled in	edicai	29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only one)	sicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	ce, and due to the c curred at the time, c	cause(s) and ma date and place,	inner as state and due to th	e cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	wara w		29c. Licens	e number	2	39d. Date signed	(Month, Da	y, Year)
0	20		30. Name and address of person who co	erena 90	0 0 0	lige field	Dr.#10	Y Freder	ick M	121	701
	Sta Registr	, 0 p	31. Date filod (Month, Day, Year) JUL 1 9 20	32. Registrar's Sig	nature /	Sport	N				1

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			Registrar 1. Decedent's Name (First, Middle, Language)	estl		Certificate of	Deam	2. Date of Death	g. No.	3. Time of Death
	Physici		Leslie Ira					Month	Day Year 2004	10:23 AM
7	/Medi Examir		4a. Facility Name (If not institution, gir			4b. City, Town, o	Location of Death		4c. County of Death	
			SINAL HOSPITAL	OF BALT	MORE	BALTIN	MORE		City	
	Funeral Director		210-10-0020	Sex 7. Ag 1 Ø M 2 ☐ F	e (In yrs. last birti 56	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April	9. Birth	place (State or Foreign into) yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl f sho	ō	Md. Baltim	ore		isterstown				1 Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	eath wit		2104 Emor	y Rd.	Ever in 11 S		1136	nooite Van an Na	U.S.A.	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or tiems 23e or 28a-f show or other traumatic event, the Modical Example must be notified at	d by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
2	"natu	iete	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>		Decedent's Usual Occupa Give kind of work done	during most of work	sing 10	6b. Kind of Business/li	ndustry
12	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use retired Supervisor)	м	d. Aviatio	n Admin.
0 0	filed Hygin other ent, t		17. Father's Name (First, Middle, Last)		Dupervisor	18. Mother's Nam	e (First, Middle, Ma		11 2100012014
<u>la</u> n	Aental Aental rked	To Be	Edgar Rud	olph Coghi	11			y Louise		
ary	2 should and Men Is marke surmatic		19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Street a	and Number or Rui	al Route Number,	City or Town, State, Zi,	p Code)
≥	and sealth m 27		Mary Coghill -	Wife		04 Emory Rd			aryland 21	136
Baltimore,	Pages 1 nent of H nnt: If ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemetery Evergr	Disposition (Name of crematory or other place een Mem. Ga	rdens Ju		oc. Location - City or T O4 Finksbu	
Balti	permit. Pages 1 and 2 Department of Health s Importent: If item 27 It any injury or other tra		21. Signature of Fu ral ervice Lice	5000	of	22. Name and Address Eckhardt				21117
			23a. Patri. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do no	11605 Rei	sterstow	n Rd., Ow	ings Mills	Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence of	ASCVD WIT	H COMP	LI CA 1101	20	
	Examiner		Sequentially list conditions	b. ————						
	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):				
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of).				
68760,	tificate be executed g physician and as the burial-transit		l	(,				
89	g phy as the	edicai		d						
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗍 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
۵.	that the ded by detac	, Ph	Part II. Other significant conditions	ontributing to death bu	at not resulting in t	he underlying cause give	n in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
Records,	w requires that been signed t should be det							1 ☐ Yes	2 □No 3 □ Prob	pably 4 Onknown
ဂ ဂ	aw rec s bee 2 shot	Completed						24a. Was an	24b. Were auto	psy findings available
	sicien: The law certificate has l irector, page 2 s	mo						autopsy performe	d? prior to co death?	mpletion of cause of
Vital	sicien: certifica irector, p	Bec	25. Was case referred to medical examiner?				26. Place of Deatl	(Check only one)	No 1 ☐ Yes	2 NO
ot v	A 100	Lo	1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outp	atient 3 DOA Othe	r: 4 🗆 Nursing Ho	me 5 🗆 Residenc	e 6 Other (Specif	y)
ono	E e	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y Year) 28b. Tir Inji	ury Work	at ? ′es 2 □ No	28d. Describe how	injury occurred	
DIVISION	after death. I Director: After	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, farn	n, street, factory, office		28f. Location (Stree	et and Number or Rura	l Route Number
ā	s afte	Cert	4 Homicide determined	building, etc	. (Specify)			City or Town, S	State)	,
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	edicai	29a. Certifier (Check only one) Certifying Ph	ysician: To the best on niner: On the basis of and manner state	examination and	death occurred at the time or investigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
1	To t To t	Σ	29b. Signature and title of certifier	a	Low	29c. License		29d.	Date signed (Month,	Day, Year)
		-	30. Name and address of person who	completed cause of di-	(Hom 222) 7	rga Brieft		7	15,	LUUT
	10	,	DOUGLAS RAIMSEY	MD, SINAL	HoSPIT	RES (Pe. Print) AL OF BAL	TIMORE	BALTIN	IORE, MD	21215
	Star Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Sparket				
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yland	ŀ	10a. State		. County			10c. City,	Town or Lo	ocation						1	10d. Inside City Lin
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	Physici	an	1. Decedent's Name (First, Middle,								Date of Dea Month	Day	Year	3. Time o	
	/Media	al	Edwin William				41 07				July 1	14, 2004		2:17	PM M
	Examir	er	4a. Facility Name (If not institution, Heritage Nur				_	own, or Sunda	Location of	of Death		4c. County	_		
	Funeral				e (In yrs. last	birthday)	If Under		If Under	24 Hrs.	8. Date of Birth		11 t 11		or Foreign
	Director		216-09-1529 Usual Residence of Decedent	1 ⊠ M 2□F	84	Yrs.	Months	Days	Hours	Min.	Feb 7,	Year)	Mary	place (State on the contry) Land	
	nylane how		10a. State 10b. County		10c. City, T									10d. Inside C	ity Limits
	e Ma	cto	MD Baltin	iore		Dund	alk 							1 🗌 Yes	2 X No
	or 2	Dire	10e. Street and Number				10f. Zip				1	0g. Citizen of W	/hat Cou	intry?	
	s 23e	ral	7232 Germanhil		5 - 1 - 11 0	140.1			21222				SA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other then "natural", or Itams 23e or 28e-1 show appring yor other traumatic event, it e Madical Extended in 18 to notified and once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No		was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto i	cify Yes or No- Rican, etc.)		k, White,	ican Indian, , etc. nite	
21215-0036	n 72 ho "natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	(Give	dent's Usua kind of wor DO NOT us	k done a	furing most	of worki	ng	16b. Kind of Bu	siness/Ir	ndustry	
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Maryland	2 sho and I Is ma		19a. Informant's Name/Relationshi		1	19b. Mailin	g Address	(Street a	and Numbe	r or Rura	l Route Number	City or Town,	State, Zij	p Code)	
	and ealth m 27 her tr		Nancy Cross/daug	ghter			Thruw		ounda.						
Baltimore,	Pages 1 ment of H ant: If ita ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 🕅 Other (Special Control of Control o			etery, cren	sition (Nam natory or ot	ne of ther place	9)	D	ate	20c. Location -	City or T	own, State	
Balt	permit. Depart Import any inj		xmany	Wade, Dir	1	St Ba	Name and ate A	nato re,	omy B	21201	655 W.	Baltimo	re S	Street	
	/Medical Examiner	Examiner	23a. Park Enter the disease, of c shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence	ce of):	Ey y f	FA	21 L C	21	ALP Col		-	Approximat Interval Bet Onset and I	ween
P.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. A Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3 🗆	Ectopic pre					23d. Date Mon		*	Year
	es ng pe	by	Part II. Other significant condition	s contributing to death be	ut not resulting	g in the un	aderlying ca	use give	n in Part I.			s 2 No	bute to the		leath? Inknown
Vital Records,	The law requir ate has been s page 2 should	Completed									24a. Was an autops perform	ned? pi	/ere auto rior to co eath?	ppsy findings ampletion of ca	available ause of
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ō	ding Phys J. After this funeral di	tlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☐ Matural 5 ☐ Pending	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 28t	Outpatient Time of Injury		Othe Sc. Injury Work	at	2	ne 5 🗌 Reside 8d. Describe ho			(y)	
Division	al or Attanding s after death. I Director: After id in by the fune	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be Doo Place of Inju	ıry - At home, c. (Specify)	, farm, stre					8f. Location (Sti City or Town	eet and Numbe , State)	r or Rura	al Route Num	ber,
	To the Hospital within 24 hours a To tha Funerel Completely filled	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of the desis of and manner sta	examination	ige, death and/or inv	occurred a estigation,	it the time	e, date and inion, deat	d place, a	nd due to the ca	use(s) and man te and place, a	ner as si	tated. o the cause(s))
	Tot Withi Tot	Ž	29b. Signature and title of certifier	/			29c.	License	number	0 -	29	d. Date signed	(Month,	Day, Year)	
			Denino	1 R 1/8	014	11/)2	110	18		7/14/	M		
			30 Name and address of person w	no completed cause of de	eath (Item 23a	a) (Type, F	Print	7 3	/-		0	De 1/6	1		2
			31. Date filed (Month, Day, Year)	J444	21	200	1201	K	OCE	1	RUSTR	K B	12	122	2
	Sta Registr		JUL 1 7 2004	32. Hegistra	r's Signagure	Sp	palls								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY GLORIA M. CREANEY 2004 3:04 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER BALTIMORE TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 X F Director Yrs 220-18-9584 12/31/1927 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location Show 10d. Inside City Limits 'netural', or items 23e or 28a-f shov dical Exsminer must be notified at MD BALTIMORE LUTHERVILLE Completed by Funeral Director 1 ☐ Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 GURTEEN COURT UNIT 302 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ **X**o If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHTTE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 12TH GRADÉ COUNSELOR STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental F marked SIDNEY ADELUNG IDA BREWER 2 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES K. CREANEY 3 GURTEEN COURT HUSBAND UNIT 302 LUTHERVILLE, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State NEW CATHEDRAL CEM. 7/20/2004 ⁴ 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER SVEASI disease or condition resulting in death) Dara /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) exeminer Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel D (A) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)25205 July 15, 200 X

Registrar

DHMH 17 Rev 1/2001

State

W.A.

31. Date filed (Month, Day, Year)

JUL 1 9 2004

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

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6701

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oals

Charles St. Balts. md 2120x

30. Name and address of person who completed caused death (Item 23a) (Type, Print)

6Bmc

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dud1ey James William 15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Boch move

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Feb. 22, 1943 7. Age (In yrs. last birthday) peripliti UNIYERSITE 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Mary 1 and Funeral 217-40-4340 1 XM 2 ☐ F 61 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Neglical Examinal must be notified at Director Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 101 Louise Terrace 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White Completed by 3 ☐ Widowed 4 T Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First Middle Maiden Surgame) unknown Octavia 0 4 1 Pearson Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) bermit. Pages 1 and 2
Department of Health an.
Important: If item 27 is m
any injury or other Vincent Buniff, Son 101 Louise Avenue, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) July 16, 2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harman Funeral Service. P.A. M01113 7221 Grayburn Dr., St. G, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MANNER CAUSED Physician 12 months /Medical Due to (or as a consequence of): MERITY ON APPROVED BY MEDICINES EX Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed physician and s the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2×No been si 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 Ø No 13,2004 2 Accident 14:06 redestrinan Struck 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Rout Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30494 7/16/04

State Registrar

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

JAMES

31. Date filed (Month, Day, Year) JUL 1 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NINERSI

KIRTIKANT

		State of Maryland / State of Maryland / Registrar 1. Decedent's Name (First, Middle, Last)	-	artmen rtificate					Reg. No.	004	22484
Physicia /Medic		Enrico DiLuozzo						2. Date of De Month JULY	1 ^{Day} ,	$20\overset{Year}{0}$	3. Time of Death 5:04P. M
Examin	er	4a. Facility Name (If not institution, give street and number) 3402 BLUEBERRY LANE		REI	STER	Location of D			CA	ROLL	n
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last 92 Usual Residence of Decedent	Yrs.	If Under Months	Days	If Under 24 Hours	Min.	8. Date of Birt 0 690 9a	y 1 9 12	9. Birti	nplace (State or Foreign
n the Maryland r 28e-f show r rollified at	ctor	10a State 10b County 10c City, To Reist		town							10d. Inside City Limits 1 ☐ Yes 2 1 No
th with th	al Dire	3402 Blueberry Lane		10f. Zip	Code 136				10g. Citize	n of What Cou	untry?
O30	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced if Yes, spec 1 ☐ Yes 2		spanic Origin n, Mexican, P Specify:	n? (Spec Puerto P	cify Yes or No- lican, etc.)	14.	Race - Amer Black, White	
Ind 21215-0036 be filed within 72 hours at tal Hygiene. id other then "natural", or event, the Medical Example.	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	a. Dece (Give life.		I Occupa k done d e retired	ation luring most of)	f workin	g		of Business/l	ndustry
Ind be fife tal Hy d oth	To Be C	17. Father's Name (First, Middle, Last) Angelo Di Luozzo 19a. Informant's Name/Relationship (Type, Print)	Ob. Mailin	5 Add.	(Ctroot o	Vince	enz	(First, Middle,	rella	1	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic. once.			402 of Dispo fery, crer	Blue sition (Name natory or of Park	ebei ne of ther place	ry La	ane 0:	ate 2/2004	cerst 20c.Loca Bal	own,M tion-City or T	ID 21136 Town, State Te, Marylan
icate be executed Wedical Examiner physician and sthe burial-transit	edical Examiner	23a. Part1. Enter the disease or complications that caused the death. D shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listess or Lifety) that initiated events resulting in death) Last Due to (or as a consequence of the conse	o not ent							imore	Approximate Interval Between Onset and Death
death death death	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pre Other (spe					23d	. Date of deliv Month	rery Day Year
ecords, P.O. law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying ca	iuse give	n in Part I.	_	23e. Did to	1. 4	/	the cause of death?
The law ate has by page 2 st	Completed						_	24a. Was a autops perform	sy	prior to co death?	opsy findings available impletion of cause of
Division of Vital To the Hospitel or Attending Physicien: Ti within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pa	Certification; To Be		Time of Injury 6 4 farm, stre	М	Sc. Injury Work 1 Y	at ? es 2 No	28 28	City or Town	ow injury of treet and No., State)	D MOW umber or Rura	al Route Number,
Hospite 24 hours Funerel stely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death	occurred a	t the time	e date and n	laca an	d due to the c	20100/01 201	d manage ac a	caneu (5)
To the within:	Med	29b. Signature and title of certifier Wounte The Yhele Ner			License					gned <i>(Month,</i>	
Star Registra		30. Name and address of person who completed cause of death (Item 23a) Which have been sometimed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		l11 P€		Street	, Ba	ltimor	e, Ma	ryland	21201

			1 - For State Registrar		Maryland A	/ Depa		of H	ealth a		-		004	22485
	Physic	ion	1. Decedent's Name (First, Middle, L.	ist)							2. Date of D		Vasa	3. Time of Death
	/Medi		Doris		Emily		D€	elpr	att		July	13 Day	$20\overset{Year}{O4}$	6:30a. M
7	Exami		4a. Facility Name (If not institution, gi	e street and num	ber)		4b. City, T	own, or	Location o	f Death		4c. C	ounty of Deat	h
			2701 Spauldin	g Avenu	е		Balt	imo	ore					
	Funeral			Sex 7 1 □ M X □ F	'. Age (In yrs. last	• • •	If Under 1 Months	Year Days	If Under:	24 Hrs. Min.	8. Date of Bi (Month, D 03 1	rth ay, Year)	9. Birtl	nplace (State or Foreign untry)
	Director		N/A	TEM ALIF	76	Yrs.					03 1	8 28	3 Ja	maica
	pug *_		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	f sho	5			Balt									1X Yes 2 □ No
	the A	ect	MD NA 10e. Street and Number		Dai	- T IIIO								
	with e or	늅		_			10f. Zip (-	n of What Co	untry?
	eath	era	2701 Spauldin		ent Ever in U.S.	110.1	Was David	212					naica	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show is Modical Exercited. Just be notified a	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Ford	es?	13.	f Yes, specif	y Cubar	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	0- 14.	. Race - Amei Black, White	
21215-0036	Irs af	by F	3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	K) NO		1 ☐ Yes 🏖	□M √o	Specify:			S	pecify: T	Black
ò	ture the	ed	15. Decedent's E			6a Dece	ient's Usual	Occupa	ution.			16h Kind	of Business/I	
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7	iene.	E	Elementary/Secondary (0-12)	College (1-4	4or 5+)		memak					F	louse	
	Hyg Hyg other		17. Father's Name (First, Middle, Las.			110	memar		18. Mothe	r's Name	(First, Middle			
Maryland	should be filed within and Mental Hygiene. s marked other then umatic avent, tra Mar	To Be	Eric Higgins					Z	dvi	ca E	Barnet	t	,	
ž.	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship	Type, Print)	1	9b. Mailir	g Address (Il Route Numb	_	own State 7	in Code)
Ĕ	and 2 ealth a n 27 is		Rosalind Watki	ng=Dang							Balt			21215
<u>ē</u>	- 도 등 는		20a. Method of Disposition	ns-Daug	20b, Place	of Dispo	sition (Name	of			ate		tion - City or 7	
Baltimore,	Pages nent of l int: If it		1 X Burial 2 ☐ Cremation 3 [3 4 ☐ Donation 5 ☐ Other (Speci		Meac	dow dow	Rest	er place				St.	Cather	ine
薑	permit. Pag Department Important: I any injury o		21. Ign tur of A neral Servic Lice		Memo	oria 22	1 Gar	Address	ns of Facility	/31/	04	Jamai	Lca	
B	permit. Departr Importa any inju		NU BIL		$\mathcal{M}_{\mathcal{L}}$	M	Name and	F/I	I Wes	st	D-1+	.	E-M	21215
			23a. Part1. Enter the disease, or con	plications that car	used the death. D	o not ente	er the mode	of dvina	such as o	ardiac o	Balt	rrest	e, Ma	Approximate
	diense:		shock, or heart failure. List only Immediate Cause (Final	one cause on ear	ch line.									Interval Between Onset and Death
	Prysician /Medical		disease or condition resulting in death)	a	190 m		rial	-	CVIC	ev				9 mouths
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	uted 1 ansit	Ë	cause. Enter Underlying Cause (Disease or injury											
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68760,		edic	`											
ŏ	death certifica attending phate as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		me of pregnancy							23d	. Date of deliv	erv
m	death e atte d for	lcia	in the past 12 months?	4□Pregnar	th 2 Fetal dea nt at time of death		Ectopic pred Other (spec						Month	Day Year
P.0	the de by the a	hys	9 Unknown	9□ Unknow	m									
	res that igned k be deta	by P	Part II. Other significant conditions	ontributing to dea	th but not resulting	g in the ur	derlying cau	ise giver	n in Part I.		23e. Did t	obacco use	contribute to t	he cause of death?
rds	w require been sig should b	d b	lype 2 D	avere.	o Me	Mit	U5				1 🗆 '	Yes 2□N	lo 3 🗆 Proi	bably 4 Donknown
Records,	w rec	Completed	11								24a. Was	an 2	4h Were aut	opsy findings available
Re	The lav	E C							-		autor		prior to co	impletion of cause of
Vital		Ö	25. Was case referred to medical							15 1	1 Yes	2 No	1 🗆 Yes	2 No
5	Physicien: r this certificatal director,	OB	examiner?	Hospital:	patient 2 ERV		207.004	Other			(Check only o			
of	Phy or this oral o	<u>}-</u>	27. Mann Death	28a. Date of (Month,		. Time of			4 Li Nur		ne 5 Hesid			(y)
on	ding f th. : After s funera	tio	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigatio		Day Year)	Injury	м	Linjury : Work? 1 ☐ Y	? es 2.⊡N			,,	_	
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not b	e 28e. Place o	f Injury - At home,	farm, stre	et, factory, o				8f. Location (5	Street and N	umber or Rur	al Route Number,
ō	- i te	Certification;	4 Homicide	building	, etc. (Specify)						City or Tox	vn, State)		
	直ラ島田		29a. Certifier 1 Certifying Ph	ysician: To the b	est of my knowled	lge, death	occurred at	the time	a. date and	place, a	nd due to the	cause(s) and	manner as s	tated
	To the Hosp within 24 ho To the Fund completely f	edical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examination a	and/or inv	estigation, in	my opi	nion, death	occurre	d at the time,	date and pla	ce, and due to	the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier		1 0		29c. l	icense	number			29d. Date si	gned (Month,	Day, Year)
-	1		> 1(Delis ,) +	SIM	Cle di	MI) [13	63	56		7/	111	2001
	,1		30 Name and address of person who	completed cause	of death (Item 23a) (Type	Print)		-			' /	, 0) .	1
	C		Robert B	Shoche	+ Mn	2	1351	NR	elipi	lo va	AND	Stoo	Bal	to MD ²¹²¹⁸
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signature			4. 6	- IVEC	W / C	- 1/46-	0166	- :	10
200	Registr		1111 4 5 00		1.									
DH	MH 17 Rev 1/2	001	JUL 1 9 20	14 /200	w H	AND	the second							
					OR	IGINA	L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year JOSEPH E EHRLICH JULY /Medical 2004 16 6:05 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CASEY HOUSE ROCKVILL MONTGOMERY Under 1 Year Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) X□M 2□F 084-07-6264 Director 93 11/21/1910 NEW YORK Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits Directo 1 ☐ Yes 2X No N.Y. NASSAU ROSLYN HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 300 EDWARDS STREET 11577 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? traumatic evant, the Medical Examiner to Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. itam 27 Is marked othar than "natural", or Itan Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ₩idowed 4 □ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **IMPORTER** IMPORTIMG 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY RAE TEITELBAUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVERETT M. EHRLICH / SON 5210 WAPAKONETA RD. BETHESDA, MD. 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State jo i ŏ 1 ☐ Burial 2 ☐ Cremation 3 ▼Removal from State permit. Page Department of Important: If any injury or once. CEDAR PARK 4 □ Donation 5 □ Other (Specify) 07/18/2004 EMERSON, N.J. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEBILITY ADULT FAILURE TO THRIVE disease or condition resulting in death) 6 MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death for in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEVERE CONGESTIVE HEART FAILURE Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Nunknown ADVANCED DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an director, page 2 autopsy performed? CHRONIC OBSTRUCTURE PULMONARY DISEASE 1 ☐ Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) HOSPICE of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 XNatural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the 29b. Signatura 29d. Date signed (Month, Day, Year) ٥

State Registrar

31. Date filed (*Month*, *Day*, *Year*)

JUL 1 9 2004

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

all I

EVANS MARCILYN 7/14/04 @ 5:35-PM.

			Please 1	Type or Print in Black	Indelible Ink. Ensure	All Copies A	re Legible	
			For	State of Maryland / De		d Mental Hygi	ene	
			1 - State Registrar		Pertificate of Death		g. Nő) / / /	221.07
7	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last	EVANS		2. Date of Death Month	Pay 200	H 5:35 PM
	Exami	ner	4a. Facility Name (If not institution, give GILCHRIST (5. Social Security Number 6. Se	CENTER	4b. City, Town, or Location of D		4c. County of De	MORE
	Funeral Director		432-88-0184 1D Usual Residence of Decedent	M 200/F UP YES	Months Days Hours I	Min. (Month, Day,)	942 AR	lirthplace (State or Foreign Country) KANSAS
	e Marylan Se-f show	ctor	10a. State 10b. County BALTI	MORE LUTH	r Location ERVILLE			10d. Inside City Limits 1 ☐ Yes 2 No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, I'm Madical Examiner must be notified at once.	Funeral Director	10e. Street and Number 3 NESTMINST 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give	10f. Zip Code 2 1 09 3 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	Citizen of What C NTED 14. Race - An Black, Wh	STATES nerican Indian,
21215-0036	72 hours "naturel",	leted by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	Year or Dates: cation e completed) 16a. De	ecedent's Usual Occupation	working 16	Specify: Sb. Kind of Busines	s/Industry
12121	filed withir Hygiene. Ither then	Completed	Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	PUTER PROGR	RAMMER	DEFE	ENSE
Maryland	should be tind Mental I marked ol	To Be	WEBSTER P 19a. Informant's Name/Relationship (Ty	ADEN	ESS	Name (First, Middle, Ma IE GRE	GORY	
	Pages 1 and 2 shu nent of Health and int: If item 27 Is m iry or other treum		EVERT DERKSEN 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	V FRIEND 83 V	ailing Address (Street and Number of NESTMINSTER BRISTS BR	DEEWAY LUT	CONTRACTOR OF THE PARTY OF THE	EMD 2109
Baltimore,	permit. Par Department Importent: any injury once.		*4 Donation 5 ☐ Other (Specify) 21. Signature of Service License	ANATOM	22. Name and Address of Facility Daugherty Family Funera	15/04 H Home And Crematic	ANOVER	,MD
			23a. Part 1. Enter the disease, or gombli shock, or heart failure. List only or	cations that caused the death. Do not be cause on each line.	2601 Mountain Ro	ad - Pasadena MD	21122	Approximate Interval Between
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	0.1	ancer			Onset and Death
	4	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Useass or injury	Due to (or as a consequence of):				
,097	icate be executed physician and s the burial-transit	icai Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):				
O. Box 68	at the death certiticate I by the attending physi tached for use as the b	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	olivery Day Year
rds, P	n requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death?
II Records	The lay ate has page 2	Completed				24a. Was an autopsy performed	i? prior to death?	utopsy findings available completion of cause of
VItal	Physicien: this certitic ral director.	Be	25. Was case referred to medical examiner?	ospital:		eath (Check only one)		
ō	ding Phys I. Atter this funeral d	ertification; To	1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	Home 5 Residence 28d. Describe how in	6 ACther (Spe	ocify) (ESFICE
DIVISION		Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Retate)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	ledicai	one)	ician: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
•	To To Con	Σ	29b. Signature and title of certifier	uns	29c. License number 583 0 3	29d.	Date signed (Mont.	
	Y		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type 4 VVO 660/ N	e. Printi Charles ST 19	Bultmare	MD 21	204
Ì	Sta Registr		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) JUL 1 7 2004	32. Registrar's Signature	Spark			

			For State	State of Maryland / Depa		lental Hygie	ne					
			State Registrar 1. Decedent's Name (First, Middle, Last		rtificate of Death	Rag.						
	Physici	an	Harry E. Eagl	•			Day Year 22:20 M					
>	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	01 1	4c. County of Death					
	Exami		Sacred Hear	+ Hospital	Comberlance	1	Allegany					
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)					
	Director	ļ	234–38–9145 Usual Residence of Decedent	[] M 2L F 76 Yrs.		Sept 10,	1927 West Virginia					
	/land		10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits					
	a-f sh	ctor	MD Allegan	y Cumb	erland		1 ☐ Yes 2X No					
	iff the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?					
	s 23e	eral	512 Winifred Roa		21502		USA					
· _	fter de r Item iirer	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	1 Mayes 2 □ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.					
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "naturel", or Items 23e or 28e-f show ont, it e Macifical Examiner must be natified at	ρ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates: 46–47	1 ☐ Yes 2 X No Specify:		Specify: white					
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	le completed) (Give	dent's Usual Occupation kind of work done during most of worki	ng 16b	. Kind of Business/Industry					
121	within ane. than	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired) laborer		footouiss					
9	filed Hygid Sther ent, II	a	17. Father's Name (First, Middle, Last)			(First, Middle, Maid	factories den Sumame)					
a	ould be i Mental I arked o	To B	Harry Frank Eagle	1	Margan	et Ann Ho	odges					
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "naturet", or Items 23e or 28e-f show aumatic event, if a Marileal Exchinet must be notified at		19a. Informant's Name/Relationship (T)		ng Address (Street and Number or Rura	I Route Number, Cit	ty or Town, State, Zip Code)					
	and and mast mast		Linda E. Kaylor/d		14 McMullen Hgwy (-						
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic es 900.9.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Ci									
Balt	permit. Departr Importe eny inju		21. Signature of the end of the e		2. Name and Address of Facility Late Anatomy Board Litimore, MD 2120	655 W. Ba	altimore Street					
r				lications that caused the death. Do not ent ne cause on each line.			Approximate Interval Between					
>	Physician		Immediate Cause (Final disease or condition	Cerebrouxul	in Accident		Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence or).								
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ó,	cate be executed physicien and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):								
58760,	cate by	dlcal		d								
~		a)	IF FEMALE:	23c. If yes, outcome of pregnancy			20d Date of delivery					
Вох	death a atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
0	at the de by the a tached	hys	9 Unknown	9□ Unknown								
Records, F	The law requires that the death certif tte has been signed by the attending tage 2 should be detached for use an	by	Part II. Other significant conditions con	ntributing to death but not resulting in the ur	nderlying cause given in Part I.		couse contribute to the cause of death?					
000	aw require is been sig 2 should b	Completed				24a. Was an	24b. Were autopsy findings available					
		Com				autopsy performed	prior to completion of cause of death? No 1 □ Yes 2 □ No					
/ita	ysicien: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	In antital	26. Place of Death	(Check only one)						
0	Physi this o	1.	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of			6 □Other (Specify)					
Division of Vital	ding I th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	ilury occurred					
NISI VISI	Hospitel or Attending Physicien: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre	eet, factory, office		and Number or Rural Route Number,					
ā	rs after ral Director			building, etc. (Specify)		City or Town, St.						
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ad at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)					
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	/55	29c. License number	29d. (Date signed (Month, Day, Year)					
-			/ Chy	/ Landstone	D36766	J	4 14 , 2004					
				ompleted cause of death (Item 23a) (Type,	-		112 1100					
	Sta	te	DR V. Kramad; 31. Date filed (Month, Day, Year)	32. Registrar's Signature	J SVITCI CHOTISC H	umber 10	20212 an 'Uni					
	Registr		JUL 1 7 2004	bancion by	1							

		1.	For State Registrar	State	of Maryla	ind / Depa		lealth and	Mental Hyg		n. 221.00	
	nysiciar Medica xamine]	Decedent's Name (First, Middle AN) a. Facility Name (If not institution	IE.	(number)	F	OX 4b. City, Town, or	Location of Dec	2. Date of Dear Month	Day 14	Year 2:29 PM	
		3	SINAL HOSPITAL Social Security Number		LTIMORI	S. last birthday)	BALTIN				y of Death N/A	
Dir	neral ector		212-09-3122	1 □ M 2 🔀	_	90 Yrs.	Months Days	Hours Min		1913	9. Birthplace (State or Foreign Country) MD	
A IN THE Maryland	Hed at		0a. State 10b. County MD BAL	TIMORE	10c. (City, Town or Lo	ALLSTOWN				10d. Inside City Limits 1 ☐ Yes 2 🌠 No	
A with the	nhar must be notified	10	0e. Street and Number 3801 SCHNAPER [DRIVE #2	13		10f. Zip Code	21133	1	0g. Citizen of	What Country?	
WM Q3 FOX, AWNE Ind 21215-0036 be filed within 72 hours after death with the Maryland and Hygiene.	A .	2	1. Marital Status 1 ☐ Never Married 2(※ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was D Armed	Decedent Ever in 1 Forces? es 2 X No . Give or Dates:		Was Decedent of H. If Yes, specify Cuba 1 ☐ Yes 2 \ No	ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- nto Rican, etc.)		ce - American Indian, ck, White, etc. fy: WHITE	
21215-0036 within 72 hours af	it, the Madical S	Palala	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	t grade complete	e <i>d)</i> pe (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) HOMEMAKER			orking	16b. Kind of B	d of Business/Industry	
Maryland 212.	even	17	7. Father's Name (First, Middle, I		TILL	ES	MARY	ame (First, Middle, M	Maiden Suman	LEVINE		
Mand 2	8	1	9a. Informant's Name/Relationsh REUBEN FOX / HI		State, Zip Code) TOWN, MD 21133							
₹ 5 % 5	-	20	Da. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal fro	om State	cemetery, crer	sition (Name of natory or other place OUNG MEN	7/1		City or Town, State		
Baltimo	eny injury o	2	Signature of Funeral Service L	Ansee Oly	men	8	Name and Addres	s of Facility S	OL LEVINS	ON & BF	ROS., INC. LE, MD 21208	
Physi /Med	cian dical	In di	3a. Part1. Enter the disease, or shock, or heart failure. List mmediate Cause (Final isease or condition asulting in death)	-a. M'		ath. Do not ent		g, such as cardia	ac or respiratory arre		Approximate Interval Between Onset and Death	
8760, cate be executed xx	rial-transit Examiner	re	Severe Coronary Actery Disease Due to (or as a consequence of): cause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
P.O. Box 6(nat the death certific	thed for use as	IF 23	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1□Liv 4□Pre	outcome of pregr re birth 2 Fet egnant at time of iknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Dat	te of delivery nth Day Year	
rds, P quires that	be 3	1	art II. Other significant condition	ns contributing to	o death but not re	sulting in the ur	derlying cause give	n in Part I.			ribute to the cause of death?	
Vital Recordician: The law requestrificate has been	page 2		- Was sacraft and to make the						-	ed2 d	Were autopsy findings available prior to completion of cause of death?	
n of ng Phys	funeral di		5. Was case referred to medical examiner? 1	28a. Da (M	Inpatient 2 Late of Injury Jonth, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \(\text{Y}	r: 4 Nursing I	ath (Check only one Home 5 Resider 28d. Describe how	nce 6 □Othe w injury occurre	ed	
Divisio Divisio Per Hospital or Attendi Per Hours after death.			4 Homicide determine 9a. Certifier 1 Certifying	Physicien: To	ilding, etc. (Speci	owtedge, death	occurred at the time	e, date and place	City or Town,	State)	er or Rural Route Number,	
To the Hc within 24 To the Fu	ompletely file	29	(Check only 2 Medical E	VALUELIAL: OU THE	a basis of examinanner stated.	ation and/or inv	estigation, in my opi	inion, death occi	urred at the time, dat	te and place, a	and due to the cause(s)	
• 3 h	1	-	1 Donda	266	10	dr.	RES	5-000	ال ٥	ULY 11	4,2004	
	5	De	OUGLAS RAMSEY	ND, S	iNAI HOS	SPITAL	of Bautin	nore, B	ALTIMOR	CE, M	D 21215	
Re	State gistrar	31	. Date filed (Month, Day, Year)		. Registrar's Sign		hand.					

DHMH 17 Rev 1/2001

ORIGINAL

unpend item#23a,27,PER ME,G833,7/22/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jill Y. Foster 04-04604 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar RJ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year /And 0 July _13 2004 /Medical 10:44 4a. Facility Name (##not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Under 1 Year | If Under 24 Hrs. | B. Date of Birth
Months Days | Hours | Min. | Month Days Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1□M 201 217-0 8-588 Usual Residence of Decedent Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural" any hipty or other traumatic events. 10a State 10b. County Gity, Town or Location 10d. Inside City Limits 1 1 Xes 2 No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2025 121 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Race 1 Yes 2 If Yes, Give Year or Dates: 1. Never Married 2 NO 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ACI 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working)
ife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 05 14 19a. Jaformant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or T. wn, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State cemetery or other place. ⁴ □ Donation 5 □ Other (Specify) u 21. Signatury of Muneral Service Licenses R Mamo DACIW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complications of Chronic Alcoholism Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) signed by the attending physician and does detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig Completed 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autoosy performed? 1 Yes 1 Yes 2☐No 2 🗌 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 101 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Y Yes 2 □ No 1 🗌 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident To the Hospitel or Attand within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 13, 2004 person who completed cause of death (Item 23a) (Type. Print)

111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1 8 2004

		-	For State Registrar	State	of Marylar		artment of H tificate of		d Mental Hy	giene Reg. No.2	04	22691
	·		Decedent's Name (First, Midd	lle, Last)					2. Date of De	aath		3. Time of Death
	Physicia	_	Leona L. F	azenhaker					July	14, 20	Year)()(4	9:10 A M
	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, o	r Location of De	eath	4c. County		
4	Examin	Ϋ.	608 Dogwoo	d Avenue			Edg	ewood		H	Harfo	rd
	Funeral Director		5. Social Security Number 212-30-3759	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 70	If Under 24 H	Hrs. 8. Date of Birdin. June 1	lece (State or Foreign htry) ryland				
		}	Usuel Residence of Decedent							,,,,,,	110	Tyrand
	ehow		10a. State 10b. Count	y	10c. C	ty, Town or Lo	calion				1	0d. Inside City Limits
	Mar	tor	MD Ha	rford		Edgewo	od					1 ☐ Yes 2 ☑ No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Cilizen of V	Vhal Cour	itry?
	th wi	al	608 Dogwood	Avenue			21	040		U.	S.A.	
	ams	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No Lerto Rican, etc.)	o- 14. Race Blac	e - Americ k, White,	en Indian, etc.
98	within 72 hours after death with the Maryland ene. Than "naturel", or Itams 23e or 28e-f ehow he Medical Ezana na minet be notified at	by Fu	1 Never Married 2 Ma	If Yes G	2 No live		Yes 2 No	Specify:		Specify	: Wh	ite
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12	withi ene. than	Juc	Elementary/Secondary (0-12)	College	(1-4or 5+)		Housewi	fe		D	omes	tic
0	Hyg Hyg other		17. Father's Name (First, Middle	, Last)				18. Mother's	Name (First, Middle			
<u>a</u>	lid be lental ked ic ev	Andrew Fitzpatrick Anna F										
Maryland 21215-0036	shou a man		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rurai Route Numb	er, City or Town,	State, Zip	Code)
Σ	Andrew Fazenbaker - Son 609 Dogwood Avenue Ed									Marylan	d 2	1040
ore.	of He of Her		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Pomoval from		Place of Dispo cemetery, crea	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or To	own, Slate
<u>Ĕ</u>	Pag nent ant: h ury o		'4 □Donation 5 □ Other (Se	cred H	eart of .	Jesus Co	em 7/17/0	4 Balti	more	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deparament of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f ehov any injury or other traumatic event, the Medical Ezatia as must be notified at once.		21. Signature of Funeral Service	Licensee	ins	l C	Name and Address S	. Zeile	r & Son, nue Balt	Inc.	D 21	227
			23a. Part1. Enter the disease, of		<u>U-2,1.</u>	Approximate Interval Between						
	Physician		shock, or heart failure. Lis Immediate Cause (Final			e 200		LING	CANCER			Onset and Death
	/Medical		disease or condition resulting in death)		ASTATIC o (or as a conse		u ceu	2014 0	Chiveel			THE MENIN
	Examiner		Committee for our Stone									
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	cate t	ф										
9 ×	as as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							22d Day	23d. Date of delivery	
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o.		iysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unk	,		3 0 mar (0p00m)) _					
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rds,	quires n sign									Yes 2□No	3 Prob	ably 4 🗆 Unknown
Vital Record	s bee	Completed							24a. Was		Vere auto	psy findings available
æ	The lav	шо							— auto perfe	ormed?	prior to cor lealh?	inpletion of cause of
ta		4	25. Was case referred to medic	al				26. Place of	Death (Check only			20110
\geq	y ∞ 10	To B	examiner?	Hospital: 1	Inpatient 2	ER/Outpatier	II 3□ DOA Oti	ner: 4 🗌 Nursin	g Home 5 Res	idence 6 Othe	er (Specif	y)
J of	ng Ph ter th neral		27. Manner of Death 1 Najural 5 □ Pend	28a. Dal	e of Injury onth, Day Year)	28b. Time o	28c. Inju Wo	ry at rk?	28d. Describe	how injury occurr	ed	
<u>S</u>	Attending r death. ector: After by the fune	atic	2 Accident inves	tigation			M 1	Yes 2 No				
Division	or Att after de Directi	Certification:	3 Suicide 6 Coule 4 Homicide deter	mined 28e. Pla	ce of Injury - At I ding, etc. <i>(Spec</i>	nome, larm, st ify)	reet, factory, office		281. Location (City or To	(Street and Numb) wn, State)	er or Rura	I Route Number,
	pital urs a eral C		29a. Certifier	ing Physician: To t	he had of my ka	owledge deat	h assured at the time	mo data and al	loss and due to the	cauca(a) and ma		lated
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	To the To the comp	×	29b. Signature and title of certif			/	29c. Licen			29d. Date signed		
)	C1		De grand	HEIMI	OWE157/	Ducoragi	ST D 5	1555		07-15	- 20	04
	X		30. Name and address of person SEIN AUNG		use of death (Ite	m 23a) (Type,	Print) UARE DE	eive , 6	BALTIMOR	e mo	212	37
F	Sta Regist		31. Date filed (Month, Day, Yea	/	Registrar's Sign		uks					

		For State Registrar	State o	f Maryland / De	partment of ertificate of			giene Reg. No: () ()	1 001	0.0	
Physic	ian	Decedent's Name (First, Middle					2. Date of Dea Month	ath CUU	Yeer 3. Time of	Death	
/Med	ical		sworth		ardner_	or Location of Deat		6, 2004 4c. County	2:17	_ A M	
Exami	ner	4a. Fecility Name (If not institution, 9401 Avondale F	100	n <i>ber)</i>		imore			altimore		
Funera	_		6. Sex	7. Age (In yrs. last birtho	ay) If Under 1 Yea	r If Under 24 Hrs	8. Dete of Birth	h		Foreign	
Director		220-20-6092	1 X XM 2□F	77 Yrs	Months Day	s Hours Min.	Sept. 2	8,1926	9. Birthplace (State or Country) Maryland		
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City	y Limits	
Maryl:	Ď	Maryland Baltin	moro	Balti	more				1 ☐ Yes	2 X No	
r 28a	Directo	10e. Street and Number	nor e	Daici	10f. Zip Code			10g. Citizen of W	/hat Country?		
th with		9401 Avondale	Road		21	.234		U.S	U.S.A.		
tems	Funeral	11. Marital Status	Armed Fo	rces?	 Was Decedent of If Yes, specify Co 	f Hispenic Origin? (S Jban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc.		
rs afte	by F	1 Never Married 2 X Marri 3 Widowed 4 Divorced	ed 1 XYes If Yes, Giv Year or D	re 10/15	1 ☐ Yes 2 🛣 N	o Specify:		Specify	White		
il Z I 3-UU30 within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28a-f show ha Mydical Extrainer mast be recitified at		15. Decedent	's Education	16a. De	ecedent's Usual Occ	supation	rking	16b. Kind of Bu			
ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)		ne during most of wo red)	ining				
A 5 6 5 .		11 17. Father's Name (First, Middle, I	(act)		Printer	18 Mother's Na	me (First, Middle,		Printing		
- 0 # 0 •	Be C		Feige	0 /							
- 755	2	Hugh F. Ga		19b. M	ailing Address (Stre	Sadie et and Number or Ri			State, Zip Code)		
2 5 # 2 E		Shirley Gardn	er Wif		1 Avonda		Baltimor	e, Mary	land 21234	!	
Ore,		20a. Method of Disposition 1 🗆 Burial 2 🗘 Cremation	3 ☐Removal from	State	sposition (Name of crematory or other p		Date	20c. Location -	City or Town, State		
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Daltimor permit. Pages Department of I Important: If itt any injury or or once.		21. Signatur of Funeral Service	Lipensee Lipensee		1050 Yor	tress of Facility Ru	ick lowso Towson,		Control of the Contro	ic.	
		23a. Part1. Enter the disease, or shock, or heart failure. List	V -	aused the death. Do not					Approximate Interval Betw		
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Geath certific attending per attending per defor use as in	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	oirth 2 Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)			Mor	e of delivery oth Day Yo	ear	
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ecords faw require as been signs 2 should to	ted	13216006060	c4-1 c (-a	rdiovasculo	in 19166	α Σ (1 🖫	es 2 □ No	3 ☐ Probably 4 ☐Ur	nknown	
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Of VITAL Physician: 1 rithis certificat ral director, p	To Be	examiner?	Hospitals	Inpatient 2 ☐ ER/Outpa	atient 3 DOA)than	ath (Check only or dome 5 Resid		ar (Specify)		
on of ding Phy h. After thi funeral of		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date					ow injury occurre			
SIOP tendir eath. or: Af	catic	2 Accident investig	gation		M 1	☐Yes 2☐No					
DIVISION or Attending after death. Director: Afte	Certification:	4 Homicide determ	ined 289. Place	of Injury - At home, farming, etc. (Specify)	, street, factory, offic	ce ·	City or Tow		er or Rural Route Numb	er,	
DIVISION O To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After t completely filled in by the funera	Medical C		Exeminer: On the b	e best of my knowledge, or sais of examination and/oner stated.							
o the inthin of the omple	Med	29b. Signature and title of certifie			29c. Lice	ense number	2	29d. Date signed	(Month, Day, Year)		
L > F 0		Men s	We	MN	0	41614	-	July 1	6,2004		
2041		30. Name and address of person	who completed cau	10 (1.1.1	u. 1	1	2127/		
7.0.1		31. Date filed (Month, Day, Year)	2 47-	Registrar's Signature	WILL MY	white	- March	2 mo	21236		

Registrar

DHMH 17 Rev 1/2001

JUL 1 9 2004 Same & Sports

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 626 FM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Year If Under 24 Hrs. to ALT MOR VENUE 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 03/17/ Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Hours Months Days Min. Director 215-07-2174 92 Yrs. 1912 | Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahov the Medical Exacting must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Melvin Avenue Itams 23a 21228 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 234 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must any once. Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Sales Clerk Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis Joseph Getka Anna Pauline Lasik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Getka - Nephew 110 Woodlawn Avenue Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 07/21/04 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 21. Signature of Funeral Service I David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, MD 21229 Approximate Interval Between Chiset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ·50/08 ep R /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) the Ö 9 Unknown 9 Unknown þ of Vital Records, P. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury death. investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , le o amen a MED 15,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -WilliamsoN= 3933 STLOBNS hANE ELLIEOT 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 1 9 2004

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Mary	,	artment of I		, 0	ene g. NG. () () (,	22494
	Physici /Medio		1. Decedent's Name (First, Middle, Last MAMIE GN	WEENE				2. Date of Death Month JVLY	Day Year 17 200	3. Time of Death
	Examin	er		UTY GENERA		TAL	or Location of Death		4c. County of Dea	nn
	Funeral Director		5. Social Security Number 6. Se 115-18-2289 15 Usual Residence of Decedent		yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Murch		thplace (State or Foreign ountry)
	death with the Maryland ims 23a or 28a-f show	tor	10a. State 10b. County Maryland	100	Baltin					10d. Inside City Limits 1 M Yes 2 □ No
	th with the M 23a or 28a-f ast be notified	Funeral Director	10e. Street and Number 5362 Covd	elia A	Je	10f. Zip Code	215	10	g. Citizen of What Co	ountry?
5-0036	hours after deat tural', or Itams ?	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of if Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
21215-0	s within 72 piene. r then "nat	Completed	15. Decedent's Edi (Specify only highest grad		(Give	DO NOT use retire	during most of worki	ng 1	6b. Kind of Business	
Maryland	ದ್ವರ ಕ್ಷ	To Be (17. Father's Name (First, Middle, Last) William		arley					
	and 2 s		19a. Informant's Name/Relationship (T) Willie Clary	ypa, Print) - Nepher			tand Number or Rura lelia a		-	Zip Code) 1d 21215
Baltimore,	age art: If y or		20a. Method of Disposition 1	Removal from State	ob. Place of Dispo cemetery, cren		oce)	ate 2	0c. Location - City or	
Balt	permit. F Departme Importar any injur		21. Signature of Funeral Service Licens	3 Baker 9	4 3		ukes 450 ST ST,			1e 23824
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death)	lications that caused the one cause on each line. a. Due to (or as a cor	NEVN		ing, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death A PAY 5
8760,	ate be executed nysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
P.O. Box 68	it the death certificate by the attending phys tached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	y		23d. Date of del Month	ivery Day Year		
	ires tha signed d be de	ed by Pł	Part II. Other significant conditions co		resulting in the ur	nderlying cause gr	ven in Part I.		acco use contribute to	o the cause of death? obably 4 AUnknown
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 ☑ Inpatient	2 ☐ ER/Outpatien	t 3□ DOA Ott	26. Place of Death			-16.1
ion of	ng Phys fter this ineral dii	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea		28c. Inju Wo	ry at 2 irk?] Yes 2 □ No	8d. Describe hov		спу)
Divis	ath.	at								
	tal or Attending is after death. el Diractor: After ed in by the fune	Certificat	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, stre	eet, factory, office	2	Bf. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	the Hospital or Attendi nin 24 hours after death. the Funerel Diractor: A ppletely filled in by the fu	ledical Certification:	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	28e. Place of Injury - building, etc. (Sp. sicien: To the best of my iner: On the basis of exar and manner stated.	pecify) knowledge, death	occurred at the tivestigation, in my	ime, date and place, a opinion, death occurre	City or Town, and due to the cau and at the time, dat	State) Ise(s) and manner as e and place, and due	stated. to the cause(s)
	or Atten		3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only) 2 Medical Exami	building, etc. (Sa sicien: To the best of my iner: On the basis of exar and manner stated.	pecify) knowledge, death	occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre se number	City or Town, and due to the cau ad at the time, dat	State) Ise(s) and manner as e and place, and due J. Date signed (Mont.)	stated. to the cause(s) h, Day, Year)
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t	edical	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	building, etc. (Sp. sicien: To the best of my iner: On the basis of exar and manner stated. MD ompleted cause of death	necify) knowledge, death mination and/or inv	29c. Licen:	ime, date and place, a opinion, death occurre se number	City or Town, and due to the cau ad at the time, dat	State) Ise(s) and manner as e and place, and due	to the cause(s) h, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 11:50 AM Henderson Y005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Richie 5. Social Security Number 15altimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 - 2 2 - 3 | 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1₽M 2□F Yrs. 216-28-8962 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Exacting must be redified an once. Ra 1 Yes 2 AND Funeral Director altimore ndalls town 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA ·id 4 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steamship SNOC man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilbord Henderson unningham 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 35 Sinset ynthic Henderson m)21132 Fundellstown 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-21-04 4 Donation 5 Other (Specify) 1001C 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 78, LIBI-+ 4ndallstow MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ate Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2/X/No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2/2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) MULE 6 Other Specif Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 D No Medical Certification: To this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eacelli completed cause of death (Item 23a) (Type, Print) Name and address of person v Charles St Baltmore 111 MD lehron

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 9 2004

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32. Registrar's Signature

			1 - State Registrer	te of Marylan	d / Depa		of Hea	aith and M	lental Hy	_	01	00100		
K-1	155		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	U 4	3: Time of Death		
en 3	Physici /Medi		Warren Herrman	7					Month JUIV	Day 15	Year 2004	11:45 AM		
	Examir		4a. Fecility Name (If not institution, give street a	and number)		4b. City, To	own, or Lo	cation of Death		4c. Count				
44			Stella Maris				oniu			Ba	Himo	ore		
	Funeral Director		5. Social Security Number 6. Sex 1% M 2	7. Age (In yrs. 1	Yrs.			Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 28	h v, Year)	9. Birth	place (State or Foreig intry) Yland		
poe	* =		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ecation						10d. Inside City Limits		
Mary	4 8	tor	Maryland Baltimore		Balti	more C	County	,				1 Tes 2 No		
t a	or 28a	rec	10e. Street and Number			10f. Zip C		,		10g. Citizen of	What Cou			
3	23a o	a D	4203 Darleigh Rd.				212	236		USA	USA			
de a	oms 2	ner	11. Marital Status 12. Wa	s Decedent Ever in U.	S. 13.	Was Deceder	nt of Hispa	nic Origin? (Spendo	n, Puerto Rican, etc.)			ican Indian,		
C I Z I 3-UU30 d within 72 hours after death with the Maryland	ral', or it	d by Funeral Director	1 Never Married 2CX Married 1X	XYes 2 □ No es, Give ar or Dates: WW 1:		1 ☐ Yes 2 (Specify:			ck, White by: Whi			
לה לי	dica di	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Deced (Give	dent's Usual (Occupation done duri	n ng most of work	ing		b. Kind of Business/Industry			
ig ig	. Pa	mp		lege (1-4or 5+)						Chariz	iated Lathon			
N D	Hygiene. ther than	ပိ	17. Father's Name (First, Middle, Last)	/ A	Const	ructio		Derinter						
Maryiand d2 should be file	Mental varked o	To Be	E 1 11							Name (First, Middle, Maiden Sumame) anna Davis				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ehow eny injury or other traumatic event, its Mudical Examinar must be notified an once.	13	Susan B. Herrman(Wife)	420	3 Darl	eigh		timore,			o <i>Code)</i> 21236		
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 1 ☐ Donation 5 ☐ Other (Specify)	1 from State St.	lace of Dispo emetery, cren Josepl	sition (Name natory or othe 1 Chur	of er place) ch Ce	em. 7~19		20c. Location Baltimo		own, State Maryland		
			21. Signature of Funeral Service Licensae 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236											
PI	hysician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus immediate Cause (Final disease or condition	that caused the death e on each line. ASpir ue to (or as a consequ		er the mode of	of dying, s	uch as cardiac c	or respiratory arr	est,	212)	Approximate Interval Between Onset and Death		
ate be executed	detached for use as the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequ		ular A	ccide	nt				3 months		
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Physician:	cert	00	examiner? 1 Yes 2 No Hospital	1 Inpatient 2 E	ER/Outpatient	a 🗆 Bo .	0.1	77	(Check only on	3/3	516L 222	i i i i i i i i i i i i i i i i i i i		
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UIVISION I or Attending	after death. I Director: Ald in by the fu	Certification:	2 Suiside 6 Could not be	Place of Injury - At hor building, etc. (Specify,	me, farm, stre				28f. Location (St City or Town	reet and Numb n, State)	er or Rura	il Route Number,		
To the Hospital or Attending	within 24 hours after deatl To the Funeral Director; completely filled in by the	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and	To the best of my know the basis of examinati I manner stated.	vledge, death ion and/or inv	occurred at t estigation, in	the time, d	late and place, a n, death occurre	and due to the ca	ause(s) end ma ate and place,	inner as si and due to	tated. the cause(s)		
Toth	withir To th	Me	29b. Signature and title of certifier			29c. L	icense nu	mber	2:	9d. Date signe	d (Month,	Day, Year)		
	,		Bonnee Cohen M.	0		0	4179	7		7/15/0	4			
5	(1		30. Name and address of person who complete Bennie Cohen MD 230	o Dulaney	Valley	,	Timon	i'sm MK	71093					
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 9 2004	32. Registrar's Signati										
DHMH	17 Rev 1/20	001	2004	Bener	OBIGINA	Spar	La)							

11:45 A.M.

JULY 15, 2004

HERRMAN, WARREN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Mid He, Last) 2. Date of Death HARRIS **Physician** Month Year 04:20 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital Baltmore Samaritan If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. vast birthday) 8. Date of Birth **Funeral** 10 M 20 F Months Days Hours Min Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ust by radified at BALTIMORE 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner of ŏ Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry // nigh EEL other then College (1-4or 5+) LABORER other traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle/Maiden Sumame) Pages 1 and 2 should be to nent of Health and Mental I unt: If item 27 Is marked o ANDOL 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAMILTON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematery or other place) 1 Burial 2 □ Cremation 3 □ Removal from State - OWINGS MILLS, MARYLAND permit. Page Department of Important: If eny injury or once. ŏ GARRISON TOLEST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses C. GREENE FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Esquaritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a co burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) the 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, director, page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 4 Nursing Home 5 Residence 6 Other (Specify) tilled in by the funeral 27. Manner of D ath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending s after death. death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune corr pletely t (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

5601

32. Registrar's Signature

Raven C

Many

31. Date filed (Month, Day, Year)

JUL 1 9 2004

Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records.

To the Hospitel or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** EON Year 2004 July 10, 1140 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1308 Ramblewood Street 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, **Funeral** 10 M 2□ F Months Days Hours Min 217.14.200 Director State 10b. County Town or Location Show 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 ☐ No 28a-f 10e. Street and Number 10g. Citizen of What Country? or fems 23s or Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces' 1 MYes 2 □ If Yes, Give Year or Dates: 2 Married 2 No BLACK 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOTUSE retired)

HRUFESSOR 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, The Medis once. Elementary/Secondary (0-12) EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 5124 DAVGHTGR MINGRVA St. LOVIS, MO 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility AUGHN C. GREENE FUNERACTIONE 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovasculas Diseas · therosclerotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit and Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cancer -ling 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has page 2 autopsy 2. No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1

Yes 2

No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6\(\text{Cother} \) Other (Specify) Certification: To at scene 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pendina 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie (Check only one) 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who cor

29b. Signature and title of certifier

JUL 1 9 2004

ma Registrar's Signature

cause of death (Item 23a) (Type, Print)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

July 10, 2004

111 Penn Street, Baltimore, Maryland 21201

			For State	State of	Marylar	id / Depa	artment	t of He	ealth and I	Mental Hyg	iene	
			Registrar 1. Decedent's Name (First, Middle, Last	1		Ce	rtificate	or L	eatn -		g. No.	22499
-	Physici /Medi	cal	ROSA LEE	HAL	RDMI	7 N				2. Date of Deat Month July 15	Day Year 2004	6:00 P M
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	Funeral		5. Social Security Number 6. Se.	x 7	. Age (In yrs.		If Under	1 Year	If Under 24 Hrs.		9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent]M 2/ A ∫F	7	4 Yrs.	Months	Days	Hours Min.	MARCIE 2	7,1930 NO	RTH CAROLINA
2	itled within 72 hours after death with the Maryland Hygiane. Hygiane. there it has 23s or 28s-f ehow int. It to Madical Examinar must be notified at	Funeral Director	MARYLAND N	IA	10c. Cit	y, Town or Lo	ocation	BAL	TIHO	RE CI	TV	10d. Inside City Limits 1 Yes 2 No
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Baltimor	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	NU	Illes	10 3	Name and	Address	of Facility Re	acon Th	2. FUNER	RAL HOME D. 21217
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Division of Vital Records.	iclen certifi ector	Be	25. Was case referred to medical examiner?	ospital:						h (Check only one		
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į	al or safter	Certification:	4 ☐ Homicide determined	building	, etc. (Specify	")	,,			City or Town,	State)	
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	Ċ		30 Name and adoress of person who co	mpleted cause		23a) (Туре, f		bs s	Street	B	Himone M	and w/ 21204
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3	Funeral Director		5. Social Security Number 219-40-9121		х ⊐м ХГХ Б	7. Age (Ir 6	n yrs. last birthday Yrs.	Months		If Under Hours	24 Hrs. Min.	8. Date of (Month	of Birth n, Day, Ye. 18	ar) 42	9. Birth Cou	place (State or Fore ntry) MD	₃ign
-100	faryland sound	or	Usual Residence of Deceden 10a. State 10b. Cou	inty			c. City, Town or L									10d. Inside City Lim	
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21215-0036	within 72 hours ene. than "natural", he Medical Ex	Completed t		dent's Ed ghest grad	ucation		(Giv	edent's Usua kind of wor DO NOT us	k done d	uring mos	st of work	ing	16b	. Kind of Bus			
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altimore,	t. Pa rtmen rtant:	- Internation	★Burial 2 Cremati 4 Donation 5 Othe 21. Signature of Funeral Sen			State	cemetery, cre Garriso	matory or of n For 2. Name and	est Addres	Vet	. 7				,	ills, Mo	Ę
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last		c	or as a co	onsequence of):										
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1			30. Name and address of per	AV	ompleted caus		(Item 23a) (Type	A	10	M	07	2-11	33				
	Sta Regist		31. Date filed (Month, Day, Y	ear)	32. R	egistrar's	Signature	of D									
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ORIGINAL